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A JOURNAL OF CLINICAL AND HEALTH AFFAIRS



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Abracadabra: Outcomes!

Coincidentally, on our deadline for this issue of *Minnesota Medicine*, I received a glossy promotional piece advertising a five-day, \$650 conference in



Las Vegas entitled "The Magic of Outcomes: Power to Improve Healthcare." Sponsored by Healthcare Benchmarking Systems Intl. ("Compare, Learn, Succeed") based in Bellevue, Washington, the program promises to "enhance your organization's health outcomes, identify performance improvement opportunities, and utilize the

the absence of computerized clinical data, is labor intensive. The first two are the centerpieces of the outcomes movement.

Practice variation and money have fueled the outcomes movement. Buyers of health care are asking why studies show wide variations in utilization, in prostatectomy rates, for example; and in outcomes, like pneumonia deaths. Patients and government are asking profit-laden managed care companies for proof of quality. And, witnessing the volatile changes in medical practice, all players are asking how we are going to track what we're doing.

Outcomes are supposed to answer these questions—whether for buyers, physicians, or patients is disputable. Corporate buyers want the best buy for the buck. But is "best" the plan that keeps corporate enrollees the healthiest or the happiest? Physicians want measurements that fairly assess their performance and help them improve. But should "fair assessment" include more than the yardsticks doctors were taught in medical school—should they consider measures of health or function? Like institutional buyers, patients want quality medicine at a good price. But does quality mean the lowest prostatectomy rates or the highest "satisfaction"?

Americans will need to decide how important the warm fuzzies ("I like my doctor") are compared with cold statistical constructs like quality adjusted life years (QALY), which try to quantify the value of a procedure or process. A recent *JAMA* article estimated that instituting smoking cessation guidelines would cost \$1,915 per QALY saved, a bargain in QALY terms compared with the \$105,000 per year of life saved if women aged 40 to 49 got mammograms every 18 months. What is a quality life year, how much is it worth, and do you want your mammogram denied because it is over the cutoff?

Magical answers from outcomes likely won't come from statistical legerdemain or from management hocus-pocus but from collective decisions about what's best for patients.

power of integrated comparative information." Clearly, business has bought outcomes. Whether the outcomes movement is magic, mumbo-jumbo, or more of the same is *Minnesota Medicine's* topic of the month.

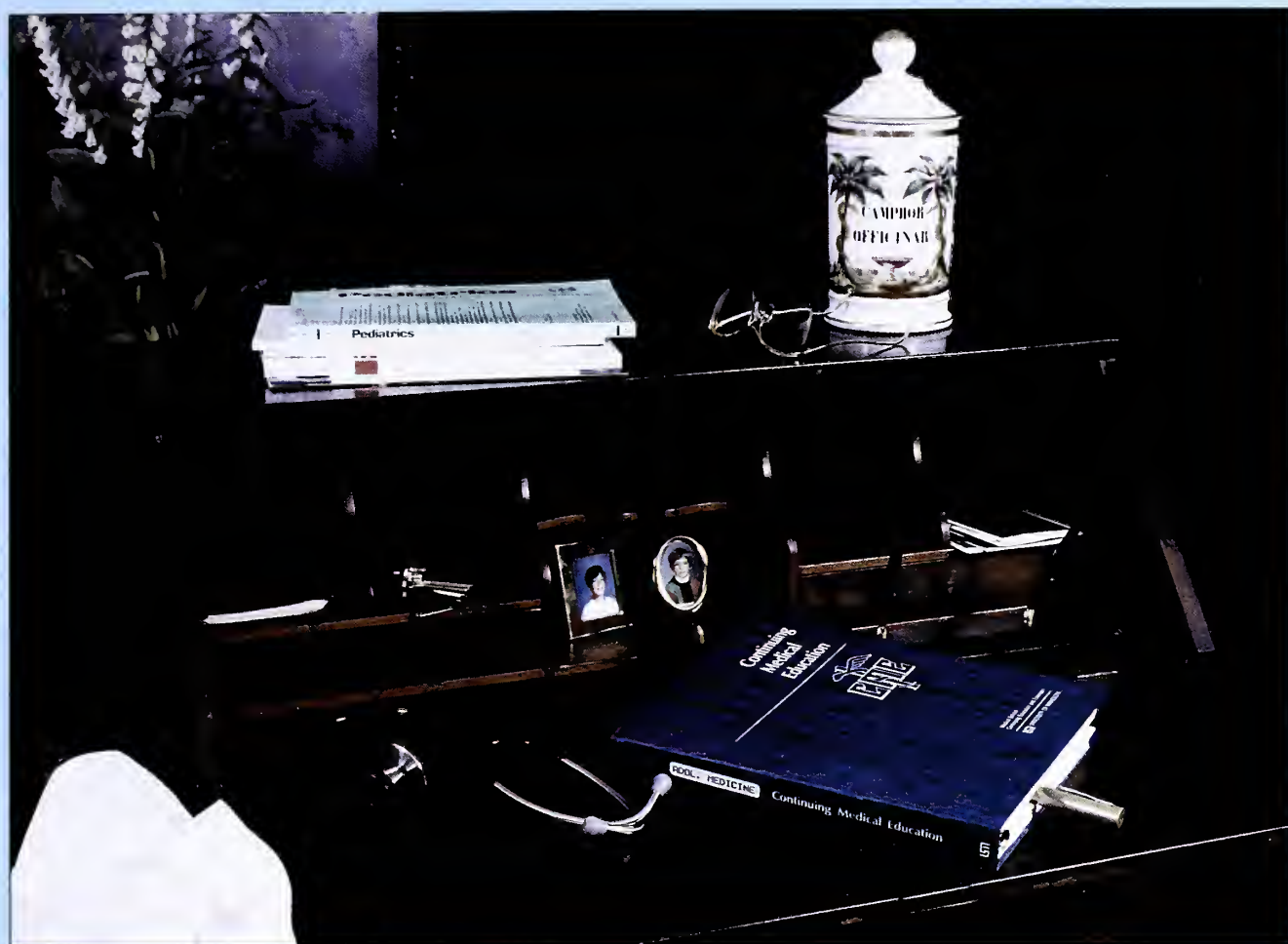
As noted in our "Measuring Up" feature story (page 18), medicine has always watched outcomes. Death is an outcome. Complications and side effects are outcomes. Now the outcomes movement is pressing the medical community to loosen up their thinking, telling them to look at patient-centered care and satisfaction. "But," physicians respond, "we have always been concerned about patients and their satisfaction. Is there anything new here, or is this just corporate-speak muddying medicine's waters?"

An article in the October 27, 1997, *American Medical News* by Raul Trillo Jr., M.D., helps to clear the mud. Trillo identifies three flavors of outcomes: 1) clinical process indicators, such as mammogram and immunization rates; 2) patient-reported outcomes, like patient satisfaction questionnaires, health surveys, and patient functional assessments; and 3) direct clinical measurements, including results of clinical trials or mortality and morbidity statistics. The third approach is what doctors have studied in medical school and, in

.....
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—Charles R. Meyer, M.D., Editor-in-Chief

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CORRECTION

In describing Dr. Bill Dobyns' research in our December story, "Bringing Up Baby," *Minnesota Medicine* incorrectly referred to the 14-3-3 ϵ gene as the 14-3-3 Σ gene. Also, Charles Nelson holds a Ph.D. as noted in the text of the story. We regret the editing errors.

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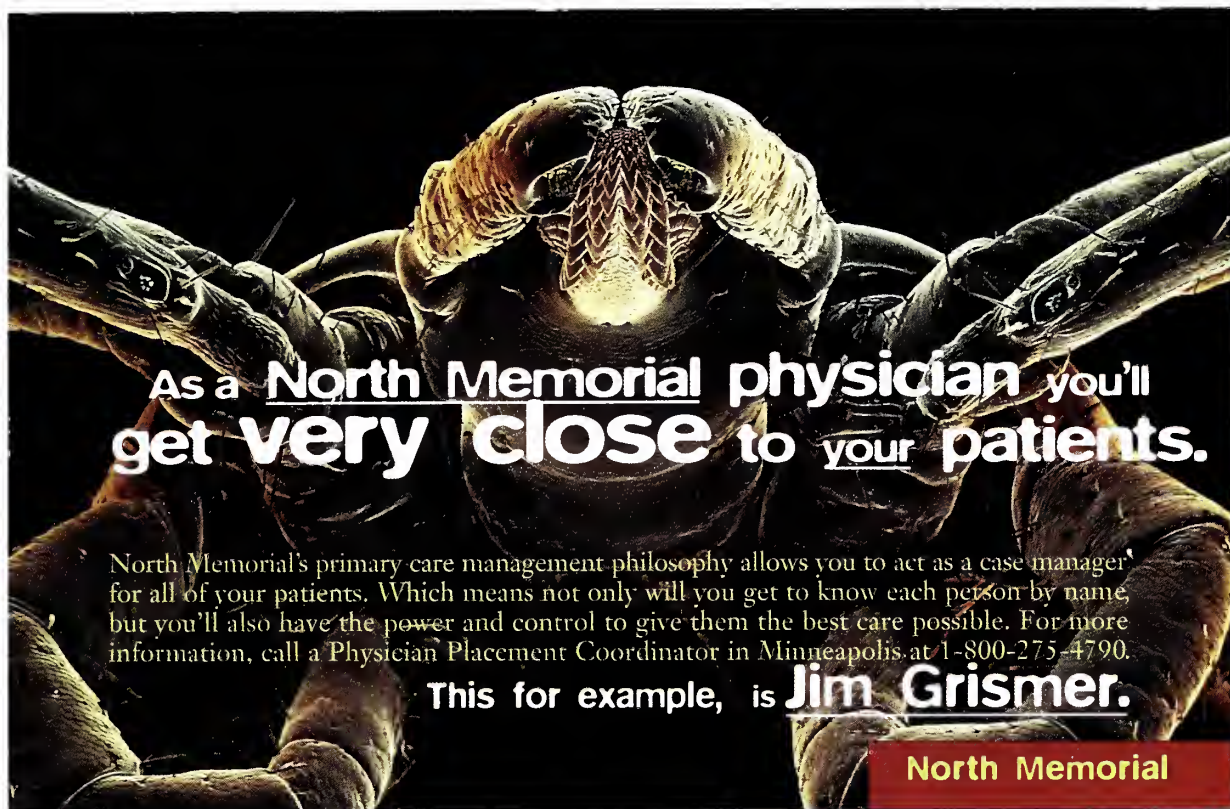
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Performance Measurement: A Good Idea in Theory

Allan Baumgarten, J.D.

The buzzing you hear is not the neighbor's snowblower, but the sound of Minnesota organizations trying to measure health care provider performance and patient satisfaction. Articles in this issue of *Minnesota Medicine* describe initiatives by the Minnesota Health Data Institute, the Buyers Health Care Action Group, the Healthcare Education and Research Foundation, state agencies, the Minnesota Council of Health Plans, and others.

There is no disagreement that performance measurement is a goal worth pursuing. Everyone—providers, health plans, purchasers, and consumers—supports publicly the notion of measuring quality and sharing that information, at least in some fashion. At open-enrollment time, Minnesotans are barraged with newspaper inserts, web sites, and piles of glossy folders, all intended to spread the word about quality comparisons.

Why evaluate performance and make the information available? For most people, the answer lies in holding providers more accountable (to whom is not always clear) and turning employers and consumers into savvy purchasers who will buy on the basis of measured quality, not just price. I suggest that using data as an effective tool to support purchasing strategies is not at hand and won't be until some

indefinite point in the future. If the expense and effort required to measure performance can be justified, the results would have to be used to help providers improve how they practice.

In theory, comparative information enables consumers and employers to make better choices. Employers offering health benefits could choose the health plans that contract with physicians and hospitals with the best outcomes, excluding those whose performance falls below the standard. Health plans would get a clear message that purchasers expect them to select their network providers based on quality measures.

Consumers, in turn, could also bring their business to certain health plans and physicians on the basis of those evaluations. During open enrollment, they would compare information on health plans' overall performance as well as information about participating clinics. And, when consumers became patients—required surgery or were diagnosed with a chronic condition—they could find the highly ranked physicians and hospitals within their health plan's network.

That's the theory. The reality, as usual, is more complicated. The challenge is making any of this information meaningful to consumers and purchasers. What

information do they need, and will they actually use it if it is provided? There are three problems with the purchasing approach to quality measurement.

First, most working Americans don't have a choice of health plans from their employer, according to data from the Kaiser/Commonwealth National Health Insurance Survey. For most people, the only choice may come in selecting physicians or clinics within the health plan network that their employer offers.

That leads to the second problem: most reporting projects still use the entire health plan network as the unit of analysis. You can compare information about HealthPartners, Medica, and Blue Plus, but you are seeing the average of thousands of physicians' performance within those systems.

The Buyers Health Care Action Group has helped to create a body of data at a care-system level, and some health plans are taking the same approach. Still, while presenting more specific data is an improvement, it leads to the third problem: it's unclear what data should be reviewed. The most widely used measures of health plan performance are the HEDIS (Healthplan Employer Data Information Set) reports. But looking at a health plan's HEDIS report is of limited value.

It will tell you, for example, what proportion of women in a certain age cohort received a mammogram in the past year. However, it will not tell you anything about the quality of the screening or what happened if a tumor was detected—what was the course of treatment? What was the survival rate after six, 12, and 18 months?

How could performance information be used? Here are two examples from other Midwestern states. First, the Health Action Council of Northeast Ohio (in the Cleveland area) recently announced a new initiative to designate a series of frequent procedures or conditions and contract them to specific hospitals. It selected the hospitals using the outcomes information generated by Cleveland Health Quality Choice (CHQC), which collects and reports hospital performance on those procedures. Its original designers included Minnesotans Walter McClure and Dale Shaller, who sought to link performance measurement with a “buy right” strategy of health care purchasing. But CHQC has lost momentum in recent years. While it continues to churn out semiannual reports, no health plans or employers were making significant contracting or purchasing decisions based on their measures.

General Motors initiated a “benchmarking” strategy last year, ranking all of the health plans it contracts with and using its employer contribution policy to steer salaried employees to the highest ranked plans. Unionized workers are not affected. Half the criteria are based on HEDIS measures, accreditation by the National Committee on Quality Assurance, and other measures. The other half are based on

efficiency—price, in other words. General Motors pays the full cost of enrolling in health plans that have achieved benchmark status. The company can penalize poorly performing plans by closing off new enrollment.

While both of these initiatives are worth studying, the fact that they are exceptional says a great deal about the infant state of outcome measurement and purchasing strategies. Health plan competition based on quality measures may be a desirable goal, but it is far in the future. For most employers, the decision is still a price question, while consumers make decisions based on out-of-pocket expense and the ability to

maintain physician relationships.

At the same time, data collection is demanding and expensive for physicians and hospitals. How does the provider benefit? Can outcomes measures be used to improve practice or to reward good practice? Perhaps if those goals were made the priority, providers would be more motivated to participate. **MM**

“Medical Marketplace” is an occasional column by Allan Baumgarten, J.D., a consultant on health care policy, finance, and local market strategies and the author of “Minnesota Managed Care Review,” annual reports analyzing key trends in health care markets.

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ARMED WITH ANSWERS

*Physician
and medical
researcher
Nicole Lurie
lives up to her
credo: "Don't
get mad, get
data."*

Nicole Lurie takes Howard Beale one step further. Beale was the TV anchorman in the 1976 film "Network." Written by Paddy Chayefsky, "Network" predicted in broadcasting what some people fear is now happening in medicine: a frenzy of corporate takeovers and a drop in standards in exchange for quick profits. In the fictional world of "Network," Beale was about to be laid off when he went on the air and uttered the words that became a rallying cry: *I'm mad as hell, and I'm not going to take it anymore.*

Nicole Lurie had a similar moment several years ago when she came up with the idea for a study on quality of care in HMOs. "I spent about six months making a decision that I was going to take a long sabbatical from doing research," recalls Lurie. "I was about 10 days into this self-imposed sabbatical when I literally woke up at two in the morning and was just furious about the way consumer satisfaction surveys were being used as *the* measure of HMO quality, and I thought, 'This is nuts. Who cares if the [hospital] food is hot? There's all the other stuff that affects the practice of medicine, and that's what's really important!'"

Lurie's epiphany resulted in the study "Are All Health Plans Created Equal? The Physician's View," published last September in the *Journal of the American Medical Association*. The study was based on a simple idea: ask physicians about quality of care in the health plans with which they work. Ask them what the plans do that helps them practice better medicine, and what they do that gets in the way. The questions were

so obvious that no one had bothered to ask them, which didn't surprise Lurie.

"This characterizes a lot of my work," she says. "I ask obvious questions, and then have to answer them myself because no one else has. It's turned out to be a pretty good way to solve problems."

The movement to return higher standards to broadcasting ultimately failed in "Network" (and, some might argue, in real life). But Lurie's efforts to give physicians a greater voice in the health care marketplace may have a more lasting effect, because she has something Howard Beale didn't have.

As the intense physician says, "Don't get mad, get data."

Lurie has made a career of getting data and getting noticed. In 1984, fresh out of her residency in internal medicine at UCLA, Lurie published a study in the *New England Journal of Medicine* about California's push to impose limits on Medicaid coverage. "It was my first published research as an adult," says Lurie, who was 31 at the time, "and it

STORY BY JEREMIAH CHRISTOPHER WHITTEN AND PHOTOGRAPH BY JOHN NOLTNER

kindled my passion for looking at issues of access to care for underserved populations, which has stayed with me ever since."

Lurie serves her passion by maintaining a busy schedule as both an academic researcher and a clinical physician. She is a professor of medicine and public health at the University of Minnesota, where she is also director of Primary Care Education and Research and director of the General Internal Medicine division. She also practices internal medicine there and at Hennepin County Medical Center. Lurie focuses her practice and research on health care access issues. For example, she helped set up a health center at the Andersen School in the low-income Phillips neighborhood of south Minneapolis.

But Lurie keeps getting pulled away by what she calls "these detours," such as the HMO study. Lurie admits that the study—which received prominent coverage in Twin Cities media—created extra distraction.

"It probably would have been easier if I'd done this somewhere else and didn't have to worry about living in the community where these data were released," she says. "I have relationships with docs, health plans, and people who work in government and purchasing organizations, and I don't necessarily want to destroy them. I want to be responsible and put out data that's constructive and that can be used to improve quality of care. I think I did that, but at some risk to some of those relationships."

The controversy revolved around the precious commodity in which Lurie deals: *information*. She had it, some under embargo to *JAMA*, and some in a follow-up study intended for presentation in the future. A lot of people wanted it. The project was challenging even before the data came in. The first challenge came from physicians themselves, many of whom were apprehensive about candidly sharing their opinions when surveyed.

"Some physicians were absolutely terrified of retribution, or were worried that their responses could be

discoverable by HMOs who would kick them off their panels," Lurie says. "We had protracted conversations with many physicians to assure them that their answers were not discoverable, and, in fact, that we would destroy any code book that linked physician responses, so that if anybody ever got hold of a data tape, they couldn't figure out who was who. There was a lot of paranoia."

Lurie and her colleagues overcame the paranoia and achieved a remarkable 84 percent response rate. They spent the better part of two years doing two related studies: first they asked 300 physicians—and then an additional 1,200 physicians—what health plans did that either helped or impeded their delivery of high quality care. Once Lurie saw the results of the survey—which revealed large differences in the way physicians felt about the quality of care in the health plans they practiced in—she knew she was in for some emotionally charged discussions. She and her colleagues shared the information early on with the Twin Cities health care community by privately presenting some of

Ask obvious questions, and then have to answer them myself because no one else has. It's turned out to be a pretty good way to solve problems.

—Nicole Lurie, M.D.



the data from the study without identifying the health plans. Representatives from each of the health plans studied were also shown their own data.

"There was a lot of interest in knowing which plan was which—lots of people begged and pleaded with us to break the code, but we felt we'd made a commitment not to do so." (That wasn't the case with the second study, which was released with the health

best comment I got came from a colleague who said, 'Most people have enough good sense not to do this in their own backyard.'" Lurie laughs loud and hard, with the perspective that comes from hindsight. "The way things played out, that comment was right on target."

Lurie says that researchers or other people who collect this type of data could be shielded from outside pressure by involving a neutral and responsible third party to distribute the information. "In this case, I'm happy to be the data collector. I would be happier if a neutral entity both disseminated the data and worked with all parties to use it to improve quality of care. That's our next phase."

The "next phase" will happen nationally. Lurie has received funding from the Robert Wood Johnson Foundation to perform similar surveys, measuring HMO quality from the physician perspective, in six other cities. There are currently no plans to perform another study in Minnesota.

In the meantime, Lurie continues her clinical practice at the university and Hennepin County Medical Center and her work in the community. "[It] keeps me in touch day-to-day with what the real issues are, which is important. It helps me know what the next questions are that need to be asked and answered."

Despite the distractions caused by the HMO study, Lurie has no regrets. She hopes her study raises provocative issues that will lead to new ways to improve quality of

care, as well as better dialogue between physicians and the HMOs with which they work. "In my ideal world, physicians would take the high road here. They'd look at health plan practices that seem to make things better and collectively pressure plans that don't do them to change their ways. And vice versa," she says, smiling. **MM**

Jeremiah Christopher Whitten is a Minneapolis-based media relations consultant and writer who specializes in health care issues and high technology.

ACCESS TO CARE: A FAMILY COMMITMENT

Nicole Lurie moved to Minnesota from California 12 years ago with her husband, Jesse Goodman, a physician and infectious disease specialist at the University of Minnesota. Lurie says they chose Minneapolis because "it was the best intersection of a two-career move, and it seemed like a reasonable place to raise a family." Lurie and Goodman have three sons, ages 8, 11, and 13.

With her medical research, academic responsibilities, and clinical practice, Lurie still tries to make time for hobbies. She admits to dabbling in pottery. "I'm not very good," she says, "but it's fun and it's a good way to find center."

Most leisure activities involve her children. "Hanging out and playing with my kids is wonderful," she says. "We love being outdoors, traveling, hiking, biking, those sorts of things."

Lurie and her husband try to raise their children to be socially aware, and she occasionally finds ways to include them in her medical research. She recently did a study on hunger in the patient population at Hennepin County Medical Center. "We were having a really hard time finding student interviewers who could work during daytime hours, and we were on a shoestring budget," Lurie says, "so I hired my oldest son to interview patients during his spring break. It was really neat to share with him some of the activist part of what I do, and for him to see that there are all kinds of people in the world and to start to understand the different issues and problems that people face. And he loved it because he had a job, and at the end of the week he got to buy a skateboard."

plans named.) In the end, the health plans involved requested that Lurie and her colleagues release the data from the second study—with the HMOs named—on September 17, the publication date of the first study in *JAMA*. The study was front-page news in the Minneapolis *Star Tribune* and the *Saint Paul Pioneer Press*.

Reaction from HMO administrators was, predictably, lukewarm. But her peers responded swiftly and positively. "Most people I spoke with said 'Great job, it's about time somebody asked this question.' But the

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Resurrect

W. Richey Neuman, M.D., M.P.H.

IT'S 8 O'CLOCK IN THE EVENING, and Mrs. O. is having chest pain again. Although she has had some transient episodes before, this 87-year-old woman has been doing remarkably well since her admission five days ago. She came through her protocol-dictated thrombolytic therapy without incident, and her anterior myocardial infarction evolved free of complications. But tonight, she suddenly sits bolt upright in bed, complains that she cannot catch her breath, and collapses. When the second-year resident arrives on the scene, Mrs. O. is apneic, pulseless, and unresponsive, with normal sinus rhythm on the monitor. The team begins cardiopulmonary resuscitation and initiates the ACLS protocol. I watch as she is intubated. A roller-coaster ride of differing rhythms ensues and is answered with various medications, shocks, and countershocks. The struggle for and with this dying woman continues for 35 minutes. At last it is over, and Mrs. O. is pronounced dead at 8:35 p.m.

Soon it is another day, another patient. This time it is Mr. E. He was admitted more than a week ago, with gastritis and esophageal spasm. A few days into his stay he had a subendocardial MI, but that pain was hidden within the pain of his esophagus. Now he complains of increasing abdominal pain. Or so it appears, as he clutches his belly and cries out in his native



ILLUSTRATION BY SEAN KANE

*With a desktop as clinic, this doctor finds that his
“patients” come alive through the data in their charts.*

Italian. The workup confirms the worst: ischemic bowel, likely secondary to emboli. The surgeon deems Mr. E. inoperable, given his comorbidities, and the rest of the team agrees that his prognosis is poor. After an emotional discussion with the family, the team agrees to offer comfort measures only; there will be no heroics for this unfortunate patient. For the next two days, Mr. E. shows progressive deterioration, and all I can do is stand by as he continues on his inexorable downhill course. Throughout his final day, he slumbers deeply, occasionally waking to groggily request pain medication. Then, after several episodes of bradycardia into the 40s, he becomes unresponsive and asystolic. As with Mrs. O., I am powerless to alter the outcome.

And so goes my week, one such patient after another. One person is admitted near death, another recovers enough to walk the wards and befriend the staff. All follow varied courses, but all of my patients reach the same fatal outcome. It is really quite striking: first one, then a dozen, then a hundred, all dying as I watch silently, helplessly, *knowingly*; and I am uneasy with such prescience.

I am not taking care of these patients, mind you, but abstracting data from their charts. An 80-year-old diabetic, a 71-year-old retired mechanic, a 65-year-old immigrant who has never seen a doctor in his adult life. All dead, but all coming to life—briefly—under my watchful eye. I take from them what I need: a blood pressure here, a rhythm strip there, a description of their suffering or seeming recovery. These “artifacts” become my data. The rest I leave to the patients, as they return from their fleeting resurrection on my data sheet to their resting place back in the chart.

I am slightly unnerved by my detached involvement with these patients’ lives. I find that more than just their numbers stay with me. As I page through the notes,

culling my data, I naively hope (yet know better) that this time they’ll survive the code, or that the cardiac rehabilitation or discharge planning visits will not have been in vain. I can sense their fear and the frustration of their families. I must suppress this uneasiness, however, and be comfortable with my place away from the bedside. Right now, my work is abstracting data, searching for patterns, testing hypotheses, not auscultating, treating, alleviating.

Indeed, at times it is difficult to imagine that my efforts at my desk and computer have any connection to the hospital, which pulses with activity in view just across the street. I feel like I am on the sidelines, temporarily out of the lineup, unable to roam the floors or the clinics, to lay on hands, to heal. But I know otherwise. I sense how my mentors were once where I am, churning through charts, collecting details. And now, the legacy of their patients is what guides the care of my own.

So I continue on, abstracting, observing, collecting. The questions become subjects, the subjects become numbers, the numbers become answers. I realize that at the moment my clinic is at my desktop, that these patients from the charts *are* my patients. And my helplessness fades as I begin to understand the connection of my research to the clinical world with which I am more familiar. I see that my work does have relevance to the living patients I have seen and will see. And I can be comfortable in knowing that by my “laying on of hands,” albeit mostly on charts instead of patients for now, I can still somehow help to heal the sick. **MM**

W. Richey Neuman is a physician in New Haven, Connecticut.

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INTERPRETING OUTCOMES

Measuring outcomes isn't always easy, and it's important to understand what they can and cannot provide.

Medicine has long been considered a combination of art and science. Science demands that we demonstrate that treatments and therapies benefit patients. Concerns about quality of health care and variation in medical practice patterns stimulated the current interest in monitoring and measuring health care outcomes. While this focus is important and necessary, any discussion of outcomes must examine what they can and cannot provide.

Types of Outcomes Vary

There are different kinds of outcomes: immediate, intermediate, and long-term; some qualitative, others more quantitative. Immediate outcomes for acute illnesses or events are usually straightforward, such as vaginal birth after C-section, postsurgical wound infection, or sterile urine culture after treatment for pyelonephritis.

Long-term outcomes require adequate time to demonstrate an effect, as when evaluating the treatment of chronic diseases. In a diabetic patient, for example, treatment and monitoring may affect the rate of complications such as retinopathy, nephropathy, or neuropathy. But the impact on outcome can lag years behind the alteration of a risk factor. Changes in lung cancer rates lag behind changes in smoking patterns by 20 to 30 years. It may take years to demonstrate an effect of lowering cholesterol levels on myocardial events. Screening patients for abuse in intimate relationships may not alter the prevalence of domestic violence for decades.

While waiting for long-term results, indicators based on intermediate outcomes, such as changes in risk factors, are usually substituted. Examples of intermediate outcomes include lower blood pressure following antihypertensive therapy or lower HgbA1C with insulin therapy. Some indicators are quantitative, such as HgbA1C levels or T-cell count or viral load in the course of AIDS therapy. Others are qualitative, often called quality-of-life or functional status measures.

Quality-of-life assessments attempt to measure physical, functional, mental, and social aspects of a person's life. Two people with the same medical condition, such as metastatic breast cancer, may have very different opinions about their quality of life. For one patient, living with hair loss and anorexia caused by chemotherapy may be acceptable. Another patient may

find it intolerable. Quality-of-life measures are also used to compare clinical interventions for a specific disease, such as the effects of two or three types of antihypertensive therapies or use versus non-use of hip arthroplasty. Cost-benefit and cost-effectiveness analyses also rely on quality-of-life measures to estimate the incremental cost of a program or intervention as compared with its incremental effects on health and quality of life. For example, the Bypass Angioplasty Revascularization Investigation trial compared angioplasty and bypass surgery using economic and quality-of-life measures. Angioplasty costs about half as much as bypass surgery, but often must be repeated, which makes the two procedures' costs similar at five years. Functional status comparisons showed a lower incidence of angina in the bypass group. Quality-of-life measures, including perception of health and employment status, were similar for both groups.¹

Many outcomes are actually process or interim measures, such as number of HgbA1C's in a year, percentage of annual ophthalmologic exams for people with diabetes, percentage of annual mammograms for women over age 50, or violence screening rates. Many of the HEDIS (Healthplan Employer Data and Information Set) measures used by health plans, including hospital readmission rates, hospital lengths of stay, immunization rates, and emergency department visit rates, are process measures.

Pitfalls of Outcomes

Outcomes are useful, but comparing them across groups or assessing them in small practices or rural areas can be difficult. Following are some common problems encountered in measuring outcomes.

- Can the patient population—the denominator—be defined? It may be easy to determine a population in a setting where a physician cares for a well-defined group of patients, as in a staff model HMO like HealthPartners. It becomes more confusing when a physician or a clinic contracts with several health plans, and patients can receive care where they show up (point of service). The denominator is often difficult or impossible to determine in a fee-for-service setting, where the patient has complete freedom of choice.

Defining patient population has become an issue as more preventive care and health promotion activities

BY THERESE ZINK, M.D., M.P.H., AND BARBARA YAWN, M.D., M.Sc.

are being evaluated in the physician's office. Clinics are responsible for measures like the rate of mammography for female patients, the immunization rate for children under age 2, or the number of patients over age 65 who have had a Pneumovax vaccine or annual flu immunization. Who takes responsibility for mammograms for a 50-year-old woman who sees both an internist and a gynecologist? The mammography report will probably be found in only one of the medical records. If it is difficult to define a group of patients, then this type of outcome measure may be unreliable.

- The size of the patient population is critical. In a sample with a small denominator (n), an event can appear much more important than in a sample with a large n . Infant mortality—the number of babies who die in the first year of life—is a common public health outcome measure. It may be used as an indicator of children's health, reflecting the quality of care provided by health departments, physicians, and social services for mothers and children. Minnesota's infant mortality rate is 6.7 per 1,000 births. At a hospital in a rural area with 10 deliveries a year, the death of one baby means that the infant mortality rate is 100 per 1,000 births, which is much higher than the state average. At a larger hospital that delivers 1,000 babies a year, the death of one infant during the first year means that the rate is 1 per 1,000 births, or much lower than the state average.

In the small hospital, however, if no more deaths occur for the next 14 years, the infant mortality rate would be only 6.6 for every 1,000 births in a 15-year interval. The small hospital's rate for only one year is inaccurate and misleading. Over an extended period it is more stable, but rapid changes in medical technology make it difficult to compare a cumulative rate from 1980 to 1995 in a small hospital with the 1995 rate in a large hospital.

- The size of the n also affects whether change is reflected in an outcome. It takes a lot more work to show a change in a small patient population than a large one. For example, early detection of breast cancer through mammography and breast exams is promoted as a way to lower the number of breast cancers found in later stages of disease. At HealthPartners, with over 700,000 members, the number of breast cancers diagnosed at stages three and four in 1996 was 41. The number of cancers diagnosed in one year at a small clinic is, of course, much smaller. On the other hand, the biannual mammography screening rate in Minnesota women age 50 and older is 69.9 percent.² It is easier to demonstrate an increase in the mammography screening rate in a practice (when the n is all women over age 50) than to show a decrease in the number of breast cancers detected in stages three and four.

- How is the outcome defined? HEDIS, a defined set of performance measures used by employers and HMOs, looks at the biannual mammography screen-

ing rate for women over age 50, but only for those who are continuously enrolled for at least two years. Other data sets look at annual screening rates. It's likely that the biannual rate will be better than the annual rate and will be better for women whose insurance pays for mammography.

- How long will it take to achieve the outcome? Performance monitors must be realistic about the time between intervention and measurable effect. Health promotion and disease prevention are long-term investments. It may take decades to demonstrate an impact from risk-factor reduction. In the current health care market, patients frequently switch physicians, so a physician's performance may not affect outcomes. The length of the monitoring interval can also affect outcome, as in the earlier example of infant mortality.

- The data necessary to ascertain an outcome may not be readily available. A patient may switch to another physician to complete care or move out of state. Complications from a surgical or orthopedic procedure may not emerge until much later, when the patient is under the care of another physician. Positive or negative outcomes may not be documented in the chart, and checking on the outcome may require calling the patient. Patients may choose not to receive routine care. Unless a physician has the resources and personnel to track down noncompliant patients, these patients are lost to follow-up. Few private practices have medical information systems to support patient tracking.

- Many elements that affect outcome are difficult to quantify. How do you measure the impact of spending extra time with a patient to answer questions, which improves patient care and satisfaction, but negatively affects waiting time measures? How do you quantify a physician's skill and finesse in encouraging a patient to quit smoking or to start exercising? How is a patient's willingness to change or not change behavior incorporated in an outcome measure?

Outcomes become more important as we practice with limited resources and must choose between various therapy options. The existing measures are often rudimentary and do not translate to all types and sizes of medical practice. Physicians must become familiar with the strengths and weaknesses of outcome assessments if they are to help patients interpret quality measures. **MM**

Therese Zink is a family practice physician in St. Paul who is in the process of relocating to Cincinnati, Ohio. Barbara Yawn is a family physician and director of research for the Olmsted Medical Center in Rochester, Minnesota.

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Outcomes research is alive and well.
Here's a look at who's measuring what.

MEASURING

BY MIRIAM KARMEL FELDMAN



ILLUSTRATION BY JAMES KACZMAN

ONCE seemingly a buzzword, perhaps a fad, outcomes research has now become a full-fledged movement. Patients, purchasers, physicians, and health plans are all measuring what works. And what doesn't. They're all after information that leads to better health care decisions.

The wide-ranging goal of the outcomes movement is to develop valid, reliable, and standardized tools to measure whether or not the health and well-being of patients is improved by specific clinical practices. And if it feels like it flies in the face of traditional one-patient-at-a-time medicine, that's because outcomes requires a systems point of view.

Outcomes is nothing new, of course. Long before "the movement," there was morbidity and mortality. Patients either improved under a physician's care, or they died. Those were outcomes. Today, however, the questions go beyond disease and death. Is there a better way to perform a cholecystectomy? Can the patient climb stairs after bypass surgery? Does one health plan do a better job of screening patients for breast cancer than another? Are all children in a

It's become more patient-oriented. "There's been a push away from disease and death to looking at functional measures," he says.

As the scope expands, outcomes can seem confusing, especially when everybody is speaking a different language. Clinicians, patients, employers, society all have a different perspective. The result is a confusing babble when you talk about outcomes, says Radosevich.

It may be useful to think about outcomes in terms of the "six D's." For years, clinicians and epidemiologists have studied death and disease. More recently, however, the paradigm has shifted to include the quality of life D's—disability, discomfort, and dissatisfaction. These are the concern of health services researchers and social scientists. Finally, there is the bottom-line D—dollars.

With so many dimensions and interest groups, the term outcomes means different things to different people. "Physicians don't want to hear about quality of life. They want to see the harder endpoints," says Radosevich. But patients tend to focus on quality-of-life issues. A cataract patient, for example, wants his cornea repaired, but he really

and to reward the best providers with the most business. Critics of outcomes research say that can lead to problems because the field is still evolving and results can be misunderstood.

"Although the technology of measuring outcomes is getting better, it's still in the very early stages," says Patricia Drury, senior consultant to the Buyers Health Care Action Group, a coalition of about 25 large, self-insured employers in Minnesota. "I'm sure in 20 years we'll have much more sophisticated ways of doing this," she says, adding that outcomes research already has improved from 10 years ago, when inpatient care was one of the few measures taken.

Cathy Borbas, executive director of the Healthcare Education and Research Foundation (HERF) agrees that outcomes research is at an early stage but finds acceptance for it growing. "In 1989 (the year HERF began a large outcomes study in Minnesota), there wasn't as much science behind it or acceptance by clinicians," she says.

Along with a growing acceptance is an ever-expanding number of instruments used to measure outcomes. One particular measure



given health plan up-to-date on their immunizations?

Outcomes is not a new concept, but the scope is new, says David Radosevich, Ph.D., director of the Center for Applied Research and Analysis at Stratis Health, a Twin Cities health research organization.

wants to be able to drive a car. As Radosevich puts it: "You certainly want to survive the surgery, but the bottom line has do with the ability to engage in day-to-day activities."

One point of outcomes research is to hold the medical community accountable for the care it provides

to assess quality that has been used by hundreds of health plans, including many in Minnesota, is the Healthplan Employer Data and Information Set (HEDIS). Created by the National Committee on Quality Assurance, HEDIS provides a uniform set of measures that al-

lows apples-with-apples comparisons of different health plans.

Another source for measuring outcomes is the Portland, Oregon-based Foundation for Accountability (FACCT), which is dedicated to endorsing and promoting the use of patient-oriented quality measures. FACCT, spearheaded by Paul Ellwood, M.D., is made up of 30 of the nation's largest private employers, health care consumer groups, and government purchasers of health care, including the federal Health Care Financing Administration. The Medical Outcomes Trust in Boston is another source of outcomes instruments, publications, and educational materials.

"There are a lot of good measures out there," Radosevich says. "But not every good test is a good measure of the question you're trying to answer. You have to have an understanding of what it is you want to know, and hopefully have some vision about where you want to be at the end of the project." For example, length of hospital stay may be an important measure, but it might be more important to know whether the patient can read a newspaper, see a friend, or drive a car.

Despite the pitfalls, outcomes research is alive and well in Minnesota. As Michael Scandrett, executive director of the Minnesota Council of Health Plans, says, "It's not perfect yet; it's not even excellent yet. But one way to stimulate improvement is to start using it. We should err on the side of getting the information, but [clarify] what the weaknesses are."

What follows is a sampling of some outcomes research activities in Minnesota.

Clinical Outcomes Research Center

The Clinical Outcomes Research Center (CORC) at the University of Minnesota strives to measure hard-to-gauge issues like quality of life for survivors of childhood cancer and for adolescents with scoliosis.

"People are becoming more aware of the need to use broader measures than death or readmission to the hospital to determine success or failure in medicine," says CORC Director Robert Kane, M.D., who is also a professor in the School of Public Health.

CORC was formed four years ago by researchers and physicians at the University of Minnesota's hospital and its public health and medical schools. CORC's core staff of health services researchers collaborate with medical school faculty to answer such questions as whether the use of clinical path-



Minnesota Health Data Institute

Satisfaction. That's the measure the Minnesota Health Data Institute (MHDI) cares about. Just how satisfied are Minnesotans with their health care? Measuring satisfaction may stretch the meaning of outcomes research, but it can lead to an outcome, says Walter G. Suarez, M.D., executive director of MHDI. "If people are satisfied with a product or service, that by itself is an outcome of the whole process."

MHDI is a public-private partnership governed by a 20-member board of directors composed of purchasers, consumers, providers, health plans, and state government representatives (see related story, page 30). It was created in 1993 to provide information for consumers to choose the health plan, clinic, or hospital that best meets their needs. "It's about the ability to choose, and to choose you have to have the right information," Suarez says.

MHDI conducts large-scale studies, the first of which was a comparative report of the state's health plans published in January 1996. The report, known as the patient satisfaction survey, asked more than 17,500 health plan enrollees about their overall satis-

faction with their particular health plans.

Since the majority of individuals in the state who receive health care through their employers do not have a choice of health plans, the patient satisfaction survey is considered to be of greater use to employers than to individuals. To address that information gap, MHDI is now conducting a clinic-level survey.

The clinic survey began last year with a six-month pilot project involving 11 primary care clinics in Duluth. Patients were asked 55 questions on everything from access to care, to waiting time, to communication with the provider. Focus groups in the Twin Cities and Duluth evaluated the results of those questionnaires to better understand the kind of information consumers want. Armed with that information, MHDI has begun a wide-scale survey of Twin Cities clinics.

Once the results of the clinic project are published (individual clinics will not be identified), Suarez expects to conduct a satisfaction survey at the hospital level. All of this is a way of looking at accountability of health care organizations and of evaluating their performance at a population-based level, he says.

ways actually reduces complications in medical procedures (CORC's research on the topic will be published in an upcoming issue of *Medical Care*).

Some clinicians and patient advocates view outcomes research skeptically as a pretext for cost-cutting, a tool to be used by those working exclusively on the "business" side of health care. Kane understands such suspicions but finds some irony in them. Thorough outcomes research that demonstrates effectiveness—or a lack of it—is actually the best weapon available for protecting sound standards and procedures against financially driven decisions that do not put patients' needs first, he says.

"[Outcomes research] is probably *the* key to developing a truly empirical health care system," Kane argues.

CORC staff have encountered a couple of recur-

ring obstacles in their research efforts. One, according to Kane, is a dearth of solid record-keeping. "You need good baseline data, and you need systematic follow-up information. Most medical systems don't have enough data to really do the kind of risk adjustments that you need to do," he says. "And most certainly don't do enough follow-up [data collection]."

The other big obstacle—which, Kane says, seems to be diminishing—is a lack of willing clinical partners. "It's a source of frustration. Academic clinicians are only recently recognizing that outcomes research is necessary," he says.

CORC recently published a book, "Understanding Health Care Outcomes Research" (Aspen Publishers, Inc., 1997), geared toward fellow pioneers in this burgeoning field.

Buyers Health Care Action Group

To the Buyers Health Care Action Group (BHCAG), outcomes research means everybody wins. That's why every health care system and provider group that negotiates a contract with BHCAG, a group of about two dozen self-insured employers who pay directly for the medical care of their employees, must agree to measure efficiency and effectiveness for developing practice guidelines.

"It's part of the contract because we believe you get better quality care and, in many cases, more efficiency. That gets us either a less costly service or higher quality for the same cost. We all win," says Patricia Drury, senior consultant in quality measurement and consumer information to BHCAG.

But BHCAG doesn't dictate the measures its systems should perform. "We don't say, 'Pap smears,' when they know their real problem is mammograms," Drury says. Some groups might measure increasing mammography rates, or ensuring first-trimester prenatal care, while others look at rates for colon cancer screening.

Some groups might study the management of a

chronic disease, like diabetes, and measure how often a diabetic patient receives a retinal exam.

Outcomes research is a continuous process, Drury says. It involves choosing an area to measure, reaching a consensus on how to improve care, implementing measures to change care, and finally, creating a feedback loop.

It's also time-consuming. As a way of recognizing the time such efforts take, BHCAG started a quality award program this year. One measure BHCAG is looking for is the percentage of people in a health plan who are 100 percent up-to-date on all preventive services for their age group, using guidelines established by the U.S. Preventive Services Task Force.

Measures that apply to large numbers of people are among the least developed areas of outcomes research, Drury says, but they're the ones of interest to BHCAG. Sophisticated measures already exist for more specific care, such as care of cardiac patients in coronary care units. "Our ultimate goal," Drury says, "is to distinguish across care systems to see who is most efficient and effective."



Healthcare Education and Research Foundation, Inc.

If there's a better way to perform a medical procedure, the Healthcare Education and Research Foundation (HERF), a private, nonprofit research organization in the Twin Cities, will try to find it. In 1989, HERF began the Minnesota Clinical Comparison and Assessment Program (MCCAP) to develop some "better way" guidelines in five areas: cholecystectomy, total hip replacement, cesarean birth, acute myocardial infarction, and breast cancer. "We devote our research to the application of those guidelines," says HERF Executive Director Cathy Borbas.

The cholecystectomy project, for example, evolved after a panel of physicians suggested that good rules already existed concerning which patients should receive a cholangiogram during surgery. But the rules were often ignored. Prevailing practice had been to perform the test on every patient, even though not every patient required it. MCCAP research concluded that across-the-board cholangiograms were not necessary. "It was a nice way of validating existing guidelines, which is what evidence-based medicine is all about," says Nora Morris, assistant director of HERF.

The MCCAP projects, which wound down in 1996, were designed to give physicians and hospitals internal information to use for self-assessment programs. "It was a tool to furnish information to the practitioner ... for internal CQI," Morris says. The information was shared with a consortium of 53 hospitals (60 percent of the states' hospitals), as well as HealthPartners, PreferredOne, and Medica.

HERF believes it can provide information that will positively influence decision-making and behavior of clinicians, institutions, patients, and purchasers. This should result in improved quality of care and an effective method for adopting national guidelines.

Minnesota Council of Health Plans

The Minnesota Council of Health Plans wants to take the confusion out of health care for the average consumer. "We think that's why people are nervous about health care. They're confused. They don't understand managed care or how their health plans work. That's not good. So we need to focus on getting them information," says Michael Scandrett, executive director of the council.

To achieve its goal, MCHP is creating an easy-to-read report that pulls together existing health care quality research. "We want consumers to fully understand how well Minnesota health plans are doing. We want them to have information to make informed decisions," Scandrett says.

Health Outcomes Institute: A Part of Stratis Health

There's more than one way to measure an outcome, just as there's more than one outcome to be measured. The trick is knowing what you want to know, says David Radosevich, Ph.D. "I've seen time and time again, people take an existing measure off the shelf and say, 'I could measure the health status of my members.'" But without an underlying conceptual notion of where you're headed, the results will be meaningless, he says.

As director of the Center for Applied Research and Analysis at the Health Outcomes Institute (part of Stratis Health), Radosevich helps clients ask the right questions and then finds the appropriate survey instrument to get answers. Stratis clients include managed care organizations, medical group practices, the state of Minnesota, and grant organizations, such as the Robert Wood Johnson Foundation.

One recent Stratis effort has been a Medicaid

Cardiac Surgical Research Foundation

When it comes to outcomes research, Cardiac Surgical Research Foundation (CSRF) does the garden-variety kind, studying what works and what doesn't. But in every other way, the operation is unique. Becky Petersen, R.N., director of CSRF, knows of no other private physician group in Minnesota that supports a research foundation to provide data for internal quality improvement, as well as to evaluate equipment and devices.

CSRF was established in 1993 as an independent, nonprofit research foundation serving Cardiac Surgi-

cal Associates, a 20-year-old, for-profit P.A. group in Minneapolis. In 1996, the group's 13 physicians performed some 2,500 open-heart surgeries and 550 other heart procedures.

At CSRF, outcomes research continues after patients are discharged from the hospital. CSRF wants to know whether open-heart surgery improves the patient's quality of life. Can the patient now walk three miles when, before, she couldn't get out of bed?

CSRF also uses outcomes research for internal

To date, existing comparative information has been most useful to large purchasers of health care. For example, the state's Department of Employee Relations has measured state employees' satisfaction with their health plans. Since the information is targeted to state employees, it's not very useful to other consumers, Scandrett explains. Now MCHP is putting together a report that will serve all those other individuals and small employers who lack the resources to conduct their own research.

The report, which is being prepared in conjunction with the Healthcare Education and Research Foundation, will focus on health plans, not on individual providers. It will show the strengths and weaknesses of different health plans by measuring every-

thing from consumer satisfaction to how well health plans provide preventive services. It also will compare the state against national and regional benchmarks. It will show, Scandrett says, that Minnesota plans are doing an excellent job compared with those in other parts of the country.

The Minnesota Council of Health Plans is an association of 10 health plan companies that provide coverage to more than 2 million Minnesotans. Its members are Allina, Blue Cross and Blue Shield of Minnesota, Mayo Health Plan, HealthPartners, UCare Minnesota, Metropolitan Health Plan, Altru Health Plan, Central Minnesota Group Health Plan, First Plan of Minnesota, and PreferredOne. All are licensed with the state as managed care plans.

beneficiary immunization rate study for Minnesota's Department of Human Services, to be released early this year. The study has found a wide variation in immunization rates, though less by health plan than by medical practice. "I can assure you, there's a lot of variability," Radosevich says.

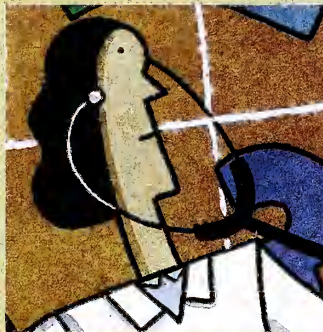
This study suggests that health plans must focus their interventions at the clinic level if they want better health for consumers. While an immunization rate study measures process more than outcome, it could lead to a medical outcome: fewer children at risk of certain communicable diseases.

Radosevich came to Stratis (formerly the Foundation for Health Care Evaluation) on a route that began in 1988, when he worked with Paul Ellwood, M.D.,

at Interstudy. In 1993, he cofounded the Health Outcomes Institute, which recently merged with Stratis Health. Despite the change in titles, the group's focus continues to be quality assessment.

Aside from the immunization rate project, Stratis is studying low-back injuries for Minnesota's workers' compensation population. The research assesses how mandatory treatment parameters for workers' compensation cases affect the outcomes of care by looking at variables such as days spent disabled and quality-of-life changes.

Stratis is involved in numerous other projects, including the development and testing of a pediatric asthma form that could help pediatricians or managed care organizations improve asthma care management.



purposes. Currently, it is trying to set guidelines for the way leg veins are harvested during open-heart surgery. From its research, CSRF discovered a new vein harvesting procedure and is trying to identify the technique associated with the fewest postoperative complications.

The harvesting study is just one of 15 ongoing CSRF projects. Others include tests of a new mechanical heart valve, a heart port for minimally invasive surgery, and a heparin monitoring system. Aside from research, CSRF educates the local and state medical community about technology and innovations in car-

diac thoracic surgery. It also develops educational tapes, publishes papers, and consults with other institutions nationwide.

There is a downside to all this, Petersen says. "It's very, very costly. It's very labor-intensive. Any time you collect data, analyze it, and utilize it, it's extremely expensive," she says. "On the other hand, we're in an age of accountability. We can no longer say what we do is right or good. We have to be able to say why we are good and what makes us unique in delivering care. We have to document that the treatments we do are appropriate."

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

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Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

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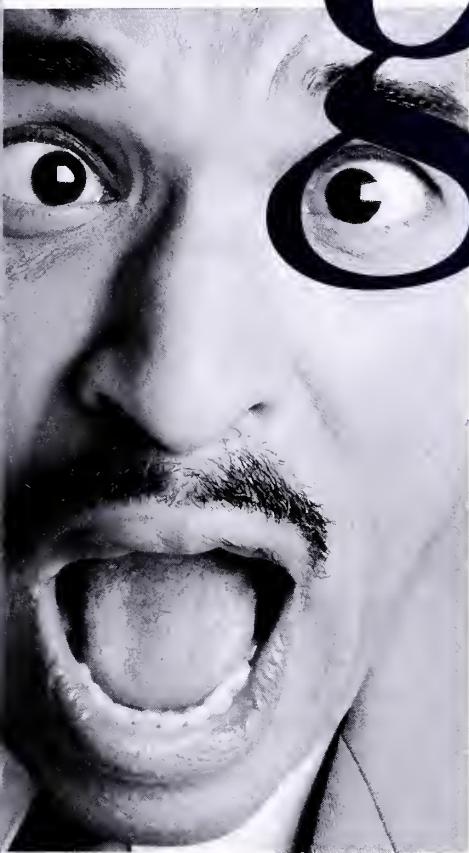
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Ins and Outs of MEASURING OUTCOMES

Outcomes measurement isn't just for hospitals and integrated delivery systems. New software allows physician practices to conduct outcomes-based studies, even without computerized records.

By L. Michael Fleischman

For the past several years, there has been a lot of talk in the medical community about quality and outcomes measurements. But since managed care organizations have focused on reimbursement methods—rather than outcomes—they have not pressured medical practices to measure quality.

Increasingly, however, managed care organizations are moving toward requiring physicians to demonstrate quality. One way physicians can accomplish this is through computerized studies of patient outcomes.

Although outcomes measurement software is increasingly powerful and versatile, few practices have installed or even considered such programs. First of all, at \$25,000 to \$40,000, plus \$2,000 to \$3,000 per physician, the software is expensive.

In addition, such programs work best when tied into an electronic medical record, which relatively few practices have. Furthermore, the programs take a relatively long time to install and master.

Nevertheless, many large practices, especially in orthopedics, cardiology, and ophthalmology, are experimenting—and having some success—with outcomes measurement software.

Cardio-Thoracic & Vascular Surgical Associates in Mobile, Alabama, first purchased its outcomes measurement software about 10 years ago but “got bogged down” because it was trying to track too much information, says John Stone, M.D.

A few years ago, however, the eight-physician group decided to try again with



ILLUSTRATION BY KRISTEN MILLER

an updated version of the software and a full-time employee to input information. It seems to be working this time around.

"We could see that managed care organizations were going to look for the groups with the best results," Stone says, adding that the only results that were going to be totally reliable "were the ones we collected ourselves."

Outcomes information, when linked to reimbursement rates, can help insurers assess the quality and value of services provided to patients. But outcomes information also can benefit physicians and patients.

Doctors benefit because these studies allow them "to set a local standard where none exists," says Chris Arslanian, Ph.D., R.N., director of research for Tucson Orthopaedic Institute in Arizona, who has conducted studies for this 20-physician practice for the past two years.

Measuring outcomes can also help physicians determine which treatments are best for patients, see where they excel, and identify opportunities to improve their practices.

Meanwhile, patients benefit because this information allows them to set realistic expectations for their own outcome and recovery. Equipped with their own personal outcomes information as well as aggregate scores for other patients who have the same condition or have undergone the same procedure, "patients are able to judge for themselves how well they are doing," Arslanian says. "They can compare their progress over time to guide their motivation."

Obstacles Remain

The main barriers to conducting outcomes studies are time, interest, and money, Arslanian says. "Outcomes studies can be time-consuming and tedious," she explains, noting that interest at a practice may fade quickly because of the lengthy process such programs entail. Furthermore, all members of a group may not be sold on the idea.

"Money is another barrier that needs to be resolved at the outset," she says, because outcomes studies can be expensive to maintain.

These studies can also be expensive to set up, because they usually require the acquisition of electronic medical records and software capable of measuring quality and successful clinical management. And they may require additional hardware and staff.

Perhaps investment in these programs and studies should be viewed in the same way that high-tech corporations view research and development. While initially a practice may not show increased profitability, in the long run the return on investment could be significant if quality outcomes help the practice garner a larger market share.

"It always seems like it's expensive, but

I guess overall it's probably not," Stone says. "I think it's an important thing for practices to do," he adds, noting that an outcomes study is both an offensive and defensive tool.

"It helps to monitor your own practice and identify areas where you're not doing as well as you should," he says. "It also allows you to have statistics on your own practice with which you feel very comfortable."



Selecting the Software and Vendor

Choosing the appropriate software and software vendor is the first step to successful outcomes studies. This requires clear objectives on the part of physicians regarding what they want to measure.

Some physicians want studies that focus on patient satisfaction, while others choose to concentrate on objective clinical data. They may want to compare their clinical outcomes to national or international databases.

Several national medical societies, as well as other groups, have

Lessons from the FRONT LINES

What should you look for when choosing a vendor for outcomes measurement software?

Christa Lane-Larsen with Associated Eye Care in Stillwater, Minnesota, has some suggestions. As administrator for this nine-physician multi-specialty ophthalmology practice, she has been tracking its patient outcomes since 1993.

Overview

What is the vision and mission of the software company?

How broad is the company's understanding of outcomes? Does it understand the perspectives and needs of payers, providers, purchasers, integrated systems, and medical device and pharmaceutical companies?

What is the company's niche? Is it specialty care, primary care, or pharmaceuticals? Do they market to providers or payers?

How long has the firm or its principals been involved in research or outcomes measurement? What is the firm's reputation?

Does the company have a solid financial position?

Can the outcomes system serve as an electronic medical record?

Technical

How were data collection tools developed? Were any doctors involved?

What hardware is required?

What is the operating system? What operating system will be used for the next generation of software? What is the timetable for future ver-

sions? Is there a cost for upgrades or ongoing support?

Can the software be networked?

What are the security levels? Are the data well protected?

Can the system do more than just hold data? For example, can it process documents or import and export data? Can it generate graphics, integrate them into your accounts receivable system, and do cost-analysis of outcomes?

Support

Will the vendor help your organization implement the system?

Do they train at their location or yours? What are the pros, cons, and costs of each approach?

Does the company offer both on-site and off-site data entry?

Do they offer phone support? If so, what are the hours and how knowledgeable is support staff?

Does the company offer other support, such as newsletters, user groups, or education?

Are manuals well written, up-to-date, and specific to your area?

Use

Does the company provide demonstration disks?

Is the system "user-friendly"? (Involve a data-entry person in this evaluation.) Does it provide standard reports as well as specific ones? Are reports easy to generate? Can you report on all fields in the database?

Who is using the product? Be sure to check references.

-LMF

established databases that allow providers to analyze and compare their own performance with national and sometimes international standards. The Society of Thoracic Surgeons, the American Society of Cataract and Refractive Surgery, and the American Academy of Orthopaedic Surgeons all have such databases. Linking up with these and other databases requires the use of appropriate software.

Ease of use is another important issue in selecting software. With some systems, the data are entered by employees working from paper forms filled out by patients, physicians, or medical staff.

Lisa Hollingsworth, director of information and communication at Cardio-Thoracic & Vascular Surgical Associates, inputs the information from data forms that are filled out by the staff. "If all the data are correct and everything is there, it takes me about two minutes, sometimes less, to put in one patient," she says. When the data forms are incomplete, however, she has to search for the answers in patient records.

Although Hollingsworth was originally hired to conduct outcomes studies on a full-time basis, the group had to find her other duties because "the software makes my job really easy," she says. But as

Stone notes, since the system isn't Windows-based, nobody except Hollingsworth is really comfortable getting into the system and pulling out results.

Tucson Orthopaedic Institute, which subscribes to MODEMS (the database of the American Academy of Orthopaedic Surgeons), enters information on touch-screen computers located in each office. A research assistant enters demographic information, such as a patient's address, date of birth, and Social Security number. Patients enter the rest while waiting to see their doctors. Information is gathered preoperatively, for a baseline, and at several time points postoperatively.

The practice has been using this system for about a year, Arslanian says, noting that she especially likes the ease of data collection. Prior to that, she had to put all the information on a spreadsheet and analyze it using a statistical analysis package. **MM**

Michael Fleischman is a health care consultant at Gates, Moore & Co. in Atlanta.

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The Minnesota Health Data Institute

Minnesota Medical Association
Department of Legislation and Public Policy

Editor's Note: Physicians and the public frequently call the Minnesota Medical Association seeking information on various public policy issues and health care industry trends. In response, the MMA has initiated a monthly informational column called "MMA Issue Brief," the first of which is presented here, to provide concise descriptions of various issues, organizations, and trends affecting physicians and their practices. Watch for future columns covering such topics as retention requirements for medical records and the emergence of physician unions. MMA Issue Briefs are also available on the MMA's Web site at www.mnmed.org under the "News" category.

What is the Minnesota Health Data Institute?

MHDI is a public/private partnership between the commissioner of health and a 20-member board of directors that represents Minnesota consumers, businesses, and health care-related organizations. MHDI is one of the first such organizations in the country to bring together various groups of organizations representing disparate views to discuss all aspects of health care. In addition to the Minnesota Medical Association, groups represented on the MHDI board include the Minnesota Hospital and Healthcare Partnership; the Minnesota Nurses Association; the health insurance industry; consumer groups, including labor unions; group purchasers; teaching and research in-

stitutions; and state agencies such as the departments of employee relations, human services, and health.

What is MHDI's mission?

To design and implement an integrated, statewide health care data system to support information needs of health care consumers, purchasers, providers, health plans, policy-makers, and researchers in measuring and improving the quality and efficiency of health care services in Minnesota.

Where does MHDI obtain its funding?

Currently, MHDI is funded by direct donations from purchaser, payer, and provider organizations. The MMA has provided \$2,000 each of the past two years. In addition to donations from private organizations, the Minnesota departments of health and human services have provided funds to MHDI through an allocation derived from the Health Care Access Fund. The Minnesota Department of Health provides \$150,000 per year as the state's allocation toward the "public" portion of the public/private partnership. In addition, the Minnesota Department of Human Services has provided \$150,000 to MHDI the past two years via a direct contract to conduct a satisfaction survey of health plans that enroll DHS patients.

How is the MMA involved with MHDI?

The Minnesota Medical Association has been involved with MHDI since the institute's inception in 1993. Two MMA representatives and two alternates sit on the MHDI board of directors, and the MMA is represented on the three major MHDI committees: the Performance Measurement Committee, the Ethics and Confidentiality Committee, and the Electronic Commerce Committee. In addition, one of the MMA representatives is on the executive committee and currently serves as the treasurer. Another physician sits on the board representing Minnesota teaching hospitals.

What projects has MHDI completed?

During the past six years, MHDI has developed several projects in which physicians have taken part. One was the "1995 Consumer Health Plan Survey Project," which provided consumers with information about Minnesota health plans. Recently, MHDI has been developing a clinic survey design that will be used to report the results of consumers' perceptions of their primary care clinic and providers. This information should prove useful for clinics to evaluate some of their key customer issues, such as waiting time, staff courtesy, and satisfaction with the care provided by physicians. When feedback is provided to an individual clinic, the clinic can then compare its facility's re-

sults with aggregate results from other clinics of like size and type. Such comparative information was not previously available and should prove useful for a clinic's internal quality improvement efforts. In addition, MHDI's Workgroup for Electronic Data Interchange is continuing to develop a process to help health care providers comply with the federal government's mandate to develop standards and guidelines for the electronic submission of claims, patient enrollment and disenrollment, eligibility, payment and remittance advice, and claims status reports.

Does MHDI plan to do any condition-specific projects?

The Performance Measurement Committee (PMC) has identified six conditions as priorities for measurement: asthma, breast cancer, depression, diabetes, ischemic heart disease, and pregnancy and childbirth. During 1998, the PMC will be working with the Healthcare Education and Research Foundation to develop a method for disseminating consumer information relating to pregnancy and childbirth, and specifically, the management of labor and delivery by cesarean section.

How will MHDI benefit physicians?

Standardized consumer surveys will allow physicians and clinics to compare their service with clinics of like size and type to implement quality improvement initiatives. Standardized electronic data forms should make physician offices more efficient at verifying patient eligibility, processing claims, billing, and conducting other insurance-related activities. Physicians would have ready access to clinic-specific information when required to report data to employer groups or others seeking such information for contracting and other purposes.

Will MHDI collect and publish physician-specific information?

No. The MHDI will only collect data down to the clinic level and will not be collecting physician-specific information.

Is MHDI data collection in line with MMA policy?

The Minnesota Medical Association monitors each MHDI meeting, and MMA staff communicate regularly with MHDI staff and MMA's physician representatives. In addition, MHDI has developed stringent policies on health care measurement methodologies, data privacy, confidentiality, and data disclosure. For

instance, the most current surveys completed by MHDI were pilot projects that allowed careful scrutiny of survey methodologies, and the survey results were not made public in any form. Participating clinics received their individual clinic-specific data and aggregate data from other participating clinics (nonidentified) to allow for comparisons.

How can I find out more about MHDI?

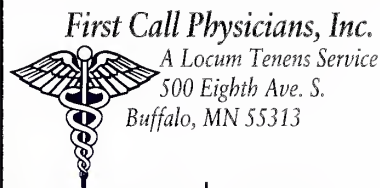
For more information about MHDI, contact Pat Hanson, MMA's manager of quality and data, at 800/DIAL MMA or 612/362-3738. The MHDI has a Web site located at: <http://www.mhdi.org/> MM



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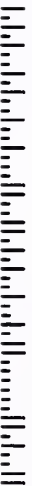
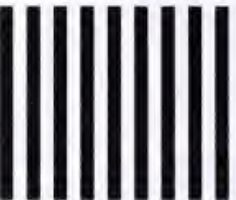
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Serving on an MMA committee is an excellent way to keep up-to-date on critical issues and to voice your concerns and opinions. The MMA benefits greatly from the committee members' generous contributions of time and expertise. To be considered for a committee, please call Jane Phillip at the MMA at 612/378-1875 or 800/DIAL MMA (342-5662). She can give you more information about the activities of each committee and about the appointment process.

• • •

MMA PUBLISHES FIRST IN SERIES OF 'ISSUE BRIEFS'

The first in a series of MMA "Issue Briefs" explores the function and structure of the Minnesota Health Data Institute and is published in this month's issue of *Minnesota Medicine*. The issue brief also appears in the Members Only section of the MMA Web page (www.mnmed.org). MMA members can find out the password by sending an e-mail request to mma@mnmed.org or by calling 612/378-1875 or 800/DIAL MMA (342-5662). Watch *Minnesota Medicine* and the MMA Web site in coming months.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Ready for 1998 Legislative Session

Three bills originating from the Minnesota Medical Association House of Delegates—two tobacco-control initiatives, and a proposal dealing with the use of Drug Enforcement Administration (DEA) numbers—top the MMA's legislative agenda for the 10-week 1998 session. This is the second half of the biennium, the "short session."

"This year's deadlines are very compact, allowing little time for hearings on bills," said Dave Renner, MMA director of legislation and public policy. "Because of the short session and upcoming election, it's not a good year to introduce major initiatives. But it is a good year to introduce ideas, and get feedback from legislators and other interested parties."

Restricting the Use of DEA Numbers

The MMA has drafted legislation to prohibit the use of a physician's DEA number for purposes other than drug enforcement. The bill is the result of growing concern among physicians about the increasing misuse of DEA numbers as universal identifiers.

At the 144th MMA Annual Meeting in September, the MMA passed a resolution pledging to work with the AMA for state and federal legislation to outlaw inappropriate use of DEA numbers. The resolution also called for outlawing the sale or release of DEA number data to non-governmental entities, and banning the use of DEA number data to track physicians' prescription histories for commercial use. More than one physician testified at the meeting about pharmacies refusing to take phone

prescriptions for antibiotics unless the physician provided his or her DEA number.

The MMA bill is modeled on a proposal introduced in the New York state legislature, said Linda Carroll-Shern, MMA associate director of state legislation. Rep. Thomas Huntley, DFL-Duluth, has expressed interest in the measure; MMA staffers are working to line up authors for this and the two tobacco-control bills.

Continuing its long tradition of fighting tobacco and promoting public health, the MMA has introduced two bills aimed at protecting children and youths from the hazards of smoking.

Prohibiting Sale of Tobacco Products to Persons Under 21

A bill to ban the sale and distribution of tobacco to youths under age 21 should generate widespread support among health and antitobacco activists. Sen. John Hottinger, who chairs the Senate Health and Family Security Committee, has indicated a willingness to sponsor the legislation.

Hottinger, DFL-Mankato, was one of two lawmakers to receive the Smoke-Free 2000 Coalition's "Legislator of the Year" award in November for his efforts in passing the Youth Access to Tobacco Act.

Requiring Day Care Homes to Be Smoke-Free 24 Hours a Day

Also on the slate is a bill that would require all licensed child care homes and centers to be smoke-free for 24 hours a day. MMA staff are attempting to line up sponsors for the measure.

Legislation continued on page 38



Viewpoint

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Paul C. Matson, M.D., Chair
MMA Board of Trustees

Why Is the AMA Sunbeam Endorsement Such a Big Deal?

Listening to the intensely personal and soul-searching debate about the Sunbeam endorsement at the American Medical Association Interim Meeting, I was struck by how strongly this issue resonates with physicians.

AMA senior staff members signed a five-year contract that gave Sunbeam the exclusive use of the AMA's trademark on certain health-related products in return for royalties. The ensuing controversy led to the resignations of several AMA executives, including P. John Seward, M.D., the former executive vice president. To avoid any repetition of this situation, the AMA conducted an internal investigation and developed ethical and professional standards to guide the AMA's corporate relationships. The AMA House of Delegates did not consider this sufficient and called for further investigation, not only of the endorsement, but also of the structure, governance, and operations of the AMA House of Delegates and Board of Trustees.

One might ask why the AMA is going to such great lengths to examine not only its internal processes, but the very essence and meaning of the organization, its elected leadership and board structure. After all, one could argue that the Sunbeam issue is nothing more than a business arrangement that didn't work, a contract that wasn't carefully analyzed,

or an oversight. I am certain that many contracts fail to fulfill the wishes of all parties to the agreement. So why is the AMA making such a big deal over this issue? I imagine that many corporate executives would ask the same question. Why not just fulfill the contract and get on with other business?

There is a strong financial incentive to do just that. As many of you have read, the possible loss to the AMA because of its litigation with the Sunbeam Corporation could be quite substantial. Sunbeam has asked the court to force the AMA to fulfill the obligations outlined in the contract or to pay compensatory and punitive damages of \$20 million.

Nevertheless, the AMA and its Board of Trustees remain adamant: as a matter of organizational conscience and public policy, this contract cannot be fulfilled. The core issue at the heart of this debate—and the reason the AMA has taken such pains to investigate itself—is the principle of trust. The AMA's very existence depends on the trust and goodwill of its physician members. The AMA—and the MMA—cannot function without the confidence and support of their members.

Physicians must be able to trust that their professional organizations will uphold high ethical standards and avoid any appearance of selling their seal of approval for cash. They must trust that the association's ac-

tivities always have the best interests of physicians and patients as a guiding principle.

The MMA was quick to call on the AMA to repudiate its arrangement with Sunbeam. At the MMA Annual Meeting in September, the MMA House of Delegates adopted a resolution taking "urgent exception" to the AMA's corporate endorsement of Sunbeam, Inc. and directed the MMA Board of Trustees to communicate its concerns to the AMA Board of Trustees. We recommended that a thorough and expedient investigation be conducted and that corrective measures be taken to prevent any future occurrences of this nature.

The MMA has never endorsed private products for the general public. The MMA's business branch, Minnesota Medical Business Resources, offers programs and services to MMA members at reduced costs, but these are benefits for members, not commercial endorsements for products sold to the public.

The distinction is important. Our public endorsement is not for sale. Patients must be able to trust that their physicians will give honest, objective opinions and will not be swayed by financial inducements.

The MMA's activities and arrangements with other organizations conform to our mission: to develop and maintain an environment in which physicians are able to deliver appropriate patient care and promote public health.

Our public image reflects our advocacy for the health and welfare of the people of Minnesota. The MMA has been in the forefront of antitobacco activities and also raised public awareness about domestic violence and violence in the media. We recently launched our Prescription for a Healthy Baby campaign to focus attention on the importance of the first three years of life and to publicize parent education classes available through Early Childhood Family Education and MELD. (See the article on page 39.)

We will continue to uphold standards of professionalism and public service.

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MMA Helps Lead AMA to Oppose Immunity for Tobacco Industry

The Minnesota delegation to the American Medical Association played a key role in the AMA's decision to reaffirm its policy against giving tobacco companies civil immunity from product liability.

At its Interim Meeting in Dallas on December 9, the AMA House of Delegates voted to reiterate its opposition to including immunity for tobacco companies in any national settlement or tobacco legislation. The settlement proposed last July could, as written, extinguish current and future civil state and class action suits—and could prevent Minnesota Attorney General Hubert H. Humphrey's case against tobacco manufacturers, slated to begin January 20, from proceeding as planned.

Concern was growing, among Minnesota delegates and in the HOD generally, about a perceived failure by the Board of Trustees to adhere to current AMA policy regarding immunity for the tobacco industry. A. Stuart Hanson, M.D., chair of the Minnesota delegation, said four leaders took the floor to speak *against* that policy during the Interim Meeting. But thanks in part to testimony by Minnesota physicians, the measure reemphasizing opposition to immunity for tobacco companies was adopted

by the House in "a pretty decisive vote," said Hanson.

Delegate Carolyn McKay, M.D., said there was no mistaking the HOD's mood—somewhat different from the mood of the board—on this issue. "The House of Delegates stood up and said, very loudly and very clearly, that the AMA does *not* want to negotiate protection for the tobacco industry," McKay said.

All Minnesota delegates and alternate delegates to the AMA attended the meeting, with the exception of Theodore L. Fritsche, M.D., who relinquished his seat in September due to schedule conflicts. The Minnesota delegation, chaired by Hanson, included delegates Robert D. Christensen, M.D.; Frank J. Indihar, M.D.; Carolyn J. McKay, M.D.; Audrey M. Nelson, M.D.; Ben P. Owens, M.D.; Andrew J.K. Smith, M.D.; and alternate delegates Raymond G. Christensen, M.D.; Kenneth W. Crabb, M.D.; Lyle Munneke, M.D.; Bruce Norback, M.D.; Thomas L. Peyla, M.D.; and John M. Van Etta, M.D.

Indihar served on the Reference Committee on Amendments to the Constitution and Bylaws. The 1997 Interim Meeting was the last AMA meeting for alternate delegate Nor-

back, whose term ended December 31. Sally J. Trippell, M.D., filled that seat January 1.

During the Interim Meeting, delegate Andrew J.K. Smith, M.D., was interviewed by telephone on Minnesota Public Radio station KNOW about the Minnesota delegation's impact on the proceedings and key issues addressed at the meeting, including managed care and Sunbeam.

Sunbeam

The disastrous Sunbeam endorsement and its continuing fallout were a major topic of discussion at the Interim Meeting. The arrangement resulted in the passage of two resolutions, both of which call for appointing ad hoc committees: one to further investigate the endorsement—with a report back to the HOD at the 1998 Annual Meeting in June—and another to study the structure, governance, and operations of the HOD and the Board of Trustees.

The ad hoc committee on structure, governance, and operations is instructed to work with an independent management firm to conduct an internal management audit "to evaluate the internal decision-making process as it relates to staff-board relationships and policy implementation of the AMA." That committee also will report its findings at the 1998 Annual Meeting.

Days before the Interim Meeting, Executive Vice President P. John Seward, M.D., resigned over the controversy, accepting partial responsibility for the Sunbeam contract. AMA Acting Chief Operating Officer Lynn E. Jensen, Ph.D., assumed the position on an interim basis while the Board of Trustees searches for a permanent executive vice president.

The AMA in November announced the formation of a task force "to develop definitive ethics and professional standards" to guide the conduct of the association's corporate relationships.

Motorcycle Safety

An MMA resolution calling for improved motorcycle safety was referred

AMA continued on page 36

HCFA Delays Enforcement of E/M Documentation Guidelines

••••• IN RESPONSE TO A REQUEST by the AMA, the Health Care Financing Administration (HCFA) has delayed enforcement of the new Evaluation and Management (E/M) Documentation Guidelines until July 1. The AMA had expressed concern that not enough time had been allowed for physicians to learn about and implement the guidelines, so the "grace period" was extended six months. Physicians are advised that in the

meantime, HCFA is conducting random audits of E/M claims; the level of E/M service billed must be medically necessary and supported by documentation in the patient's medical record. HCFA recommends that documentation of E/M services meet, at a minimum, the documentation guidelines developed jointly by HCFA and the AMA and released in 1994. Physicians with additional questions can call Kit Scally at 410/786-5714.

Carlson Proposes Using Access Fund for Medical Education

At a November 18 meeting with a number of health care representatives, Gov. Arne Carlson expressed his desire to find a way to use money from the Health Care Access Fund for medical education and research.

The Governor initiated a meeting with the MMA and other health care leaders to gather support for his plan to use as much as \$10 million from the access fund, generated by the provider tax, to offset the loss of federal money for medical education.

Dave Renner, MMA director of legislation and public policy, informed the governor that the physician members of the MMA would not support new uses of revenue from the access fund. "The MMA agrees we must find ways to fund medical education," Renner said. "But the provider tax is not the right source. Medical education is an investment that benefits all of society, and it should be funded through

broad-based taxes."

At *Monitor* press time, MMA officials were preparing for a meeting with Commissioner of Health Anne Barry to discuss possible medical education funding sources and other legislative issues.

Officials with the Minnesota Health Data Institute also have discussed the possibility of requesting money from the access fund, said Pat Hanson, MMA manager of quality and data.

The state Department of Finance recently released a revenue forecast showing that the .5 percent reduction in the provider tax, combined with increasing health care costs and expanded MinnesotaCare eligibility, will dramatically reduce the \$90 million access fund surplus over the next four years. By fiscal year 2001, the fund is projected to have a \$3.8 million structural deficit—and that's assuming that the provider tax is returned to 2 percent in the year 2000. ♦ ♦ ♦ ♦ ♦

MMA Members Spotlighted in National Media

Minnesota physicians continue to serve as national authorities on a number of health issues, from tobacco use to food safety. MMA members A. Stuart Hanson, M.D., and Robert Olson, M.D., were featured in television interviews with national media in recent weeks.

Hanson, a pulmonologist and a Minnesota delegate to the AMA, was quoted in a CBS Evening News segment December 2. In the story, anchor Dan Rather identified several well-known political figures—in both the Democratic and Republican parties—who are earning money lobbying for tobacco companies. Among the cadre of new, behind-the-scenes tobacco industry defenders are former Texas Gov. Ann Richards, former White House Chief of Staff Howard Baker, and former Republican National Committee Chair Haley Barbour.

Hanson, who is also president of the Smoke-Free 2000 Coalition and a longtime antitobacco activist, said, "I think the tobacco industry is trying to buy influence ... so they've gone to people with high visibility, like Howard Baker." According to the report, the hirelings are being employed mainly to gain swift passage of the tobacco settlement in Congress.

Olson, chief of gastroenterology at Regions Hospital, was interviewed for a November 16 segment on CBS Sunday Morning exploring food safety. Olson and one of his patients discussed campylobacter, the most common cause of food poisoning. The report highlighted Minnesota as a leading center for food safety research; state epidemiologist Michael Osterholm has received widespread recognition for his studies of campylobacter. ♦ ♦ ♦ ♦ ♦

AMA continued from page 35

to the BOT. The resolution directs the AMA to work with appropriate groups to identify options for enhancing motorcycle safety.

Early Intervention for Stroke

In lieu of an MMA resolution urging the AMA to review outcomes studies of early intervention for ischemic strokes and to help educate providers and the public about early diagnosis and treatment, the HOD passed a substitute resolution sponsored by the American Academy of Neurology. It calls for the AMA Council on Scientific Affairs, the National Patient Safety Foundation, and appropriate medical specialties "to study and make recommendations regarding the organization of systems and protocols of care for acute stroke therapy, with special attention to patient safety."

Managed Care

The HOD passed several resolutions relating to managed care, including a measure reaffirming that the physician's primary obligation is to patients. "The (resolution) emphasizes that no reimbursement considerations should interfere with or override judgments about what is best for patients," Hanson said. ♦ ♦ ♦ ♦ ♦

Physicians Notified about NHSC

In a joint letter, the MMA and the Minnesota Office of Rural Health and Primary Care notified physicians in federally designated health professional shortage areas that their clinics might qualify for assistance in recruiting physicians, mid-level providers, dental providers, or mental health professionals through the National Health Service Corps. NHSC providers are eligible for loan repayment programs and scholarships. In return, they make a commitment to practice in one of Minnesota's health professional shortage areas. For more information, call Michelle Lewis at 800/366-5424 or 612/282-3854. ♦ ♦ ♦ ♦ ♦

MMA Member Helps Lead New AMA Women Physicians Congress

MMA member Gail Gamble, M.D., is helping pilot a new AMA forum dedicated to bringing the energy and ideas of more women physicians to organized medicine. The Women Physicians Congress is envisioned as a conduit, Gamble says—to connect women physicians around the country to each other, to the AMA, and to other resources and organizations.

Gamble, an inaugural member of the Women Physicians Congress steering committee, served for three years as chair of the new group's predecessor, the AMA's Advisory Panel on Women Physicians Issues. That panel agreed that a less traditional—and inherently more inclusive—organizational structure was needed to expand the influence of women in medicine. Now, Gamble says, Internet technology will link members across the U.S. in an ongoing, interactive communications exchange.

"One of our goals is to foster and mentor leadership among women

physicians," Gamble says. "We want to help (women physicians) have a more direct, and more immediate, way of getting involved than sending someone to a meeting."

Early plans include creation of a Web site featuring clinical and health issues of interest to women, networking resources, and a bulletin board for posting meetings and events of professional interest to women physicians.

A caucus also is planned for Women Physicians Congress members and prospective members who do attend AMA meetings—but that won't be a required component of congress membership. "We want to think beyond the traditional meeting structure," Gamble says.

Steering committee members hope the congress will be able to identify and correct barriers to women in organized medicine. Though nearly a quarter of all physicians and students in 1997 were women, less than 11 percent of AMA delegates were women, according to a report by the Coun-

cil on Long Range Planning and Development. Nearly 20 percent of all AMA members in 1997—including students—were women.

In an effort to reach out to the "many capable, energetic women in medicine who have not previously found an identity in the AMA," Gamble said the Women Physicians Congress will offer one-year trial memberships to AMA members and nonmember physicians.

The AMA is changing, she added. "If we don't invite (nonmembers), they'll never be able to change their biases. We want to encourage them, to let them know that there are issues and activities (in the AMA) today that are *very* pertinent."

Gamble, a physical medicine and rehabilitation consultant in Rochester, served as chair of the MMA Board of Trustees in 1994. She said she sees herself playing a transitional role for the congress, assisting in its development and assisting new physician activists in becoming leaders.

"This is an attempt to greatly strengthen the constituency of women physicians—within the AMA, and in general," said Gamble. "We're really excited." ●●●●●

Propes Chairs Cross-Cultural Health Center

Beverly Propes, M.P.H.A., will begin serving as chair of the Center for Cross-Cultural Health in February. The center, located in Minneapolis, works to achieve cultural competency in health care. It serves as a clearinghouse, resource, and research center for health care providers and for communities of color in Minnesota. In 1996, Propes joined the University of Minnesota as executive director of the Community-University Partnership in Education and Services (CUPES), a four-year program linking Minneapolis' Phillips neighborhood with the university's Academic Health Center. Before taking the reins at CUPES, Propes directed the Community Initiatives Department at the United Way of Minneapolis. ●●●●●

Bridges Clinic Staff Relocated

●●●●● **N**EARLY A YEAR AFTER SPRING floods destroyed Bridges Medical Services—a city-owned health care center in Ada, Minnesota—staff moved in December from a temporary building into a semipermanent clinic/hospital facility. Kyle Rasmussen, clinic manager, said Bridges Medical Services will operate in the semipermanent facility until mid-1999.

In November, the MMA and the Minnesota Physicians Foundation presented a donation of \$3,460 to Bridges Medical Services. Physicians and medical facilities throughout Minnesota contributed to a special Flood Relief Fund established by the MMA and the MPF.

Ada is located in a health professional shortage area. In the months between the flood and last month's move into the semipermanent facility, the nearest emergency department was 50 miles away in Fargo.

"This will serve the community for the next year and a half," Rasmussen said. Construction is scheduled to begin this spring on a permanent facility, which will include a nursing home. The permanent facility "is going to be unlike anything else around—a totally integrated nursing home and hospital."

In the meantime, Rasmussen said, "We're getting our ER back. We're looking forward to it."

MMA Officers, Members, Staff Quoted in Managed Care Series

The Minneapolis-based *Star Tribune's* six-part series on managed care included interviews with several MMA members, officers, and staff. The "Wellness Gap" series was published December 6 through 12 (go to www.startribune.com on the Web).

Reporters spoke to MMA President Kent S. Wilson about widespread reluctance among physicians to criticize health plans. "I'm extremely disturbed when doctors surveyed say they are afraid," Wilson said. "Physicians as a group must 100 percent universally feel they can be patient advocates.... Very honestly, the physician as patient advocate has very little protection."

Dave Renner, MMA director of legislation and public policy, spoke about how doctors told the MMA that they felt pressured not to speak out when the Legislature was considering the bill requiring 48-hour postpartum stays.

"It was subtle. It was not a case of 'We will not pay,' but it was fear-related," Renner said.

Reporters said salaried doctors who work for one health plan were more positive about their practices than doctors who treat patients covered by several plans. Joseph Rigatuso, M.D., a pediatrician and member of the MMA Board of Trustees, said, "There have not been restrictions on my practice." But he added that the doctor-patient relationship was being eroded in the competitive health care environment. "There's just so much churn, so much competition; patients this year are not our patients next year."

Karen Dickson, M.D., a Minneapolis psychiatrist and member of the MMA Board of Trustees, commented on the *Star Tribune*-Harvard University survey finding that nearly 20 percent of Minnesota doctors reported they had been refused permission to provide mental health treatment, or refer their patients to such treatment, during the past year. "They remain as dysfunctional as ever; they're just not in the mental health system because we kicked them out."

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Legislation continued from page 33

State law currently requires day-care homes and centers to be smoke-free during hours of operation.

The bill may face an uphill battle. Welfare reform has sent more parents into the work force, creating a larger demand for daycare—so the mood at the Capitol leans toward loosening restrictions on child care, not tightening them, Renner said.

Access Fund, 'Direct Access,' KidCare

The MMA also will continue to voice its support in the Legislature for finding broad-based funding options for the MinnesotaCare program. And while the MMA opposes Gov. Carl-

son's proposal to use money from the Health Care Access Fund for medical education (see article on page 36), the association strongly supports increasing state funding for medical education and research, Renner said.

Legislation ensuring "direct access" to chiropractors is anticipated this year. In October, the state Department of Health ruled that HMOs can still require their members to obtain a physician referral before seeing a chiropractor. The Minnesota Chiropractic Association had argued that a 1994 law giving consumers "equal access" to chiropractors meant "direct access," but department officials disagreed. The ruling stated that health plans must ensure access to chiropractic care, but add-

MMA Invites Participation in '2 Smart 2 Smoke'

• • • • • THE MMA AND THE Smoke-Free 2000 Coalition invite component medical societies and clinics to join in a partnership to bring an innovative antismoking program—the National Theatre for Children play "2 Smart 2 Smoke"—to the children of greater Minnesota. Allina Health Systems is sponsoring the plays in the Twin Cities metropolitan area. Sponsors will help prevent children from starting to smoke, and at the same time will gain public recognition for their generosity. Posters and workbooks are emblazoned with the sponsors' names in each community, and the theater arranges for all publicity. To learn more about this partnership opportunity, please call Lorrie Holmgren at the MMA at 612/378-1875, or 800/DIAL MMA (342-5662).

ed that HMOs have historically used primary care providers as "gatekeepers" to manage their enrollees' access to the services of specialty care providers.

This session may see legislation dealing with KidCare. State lawmakers and Department of Human Services officials have been discussing ways to secure Minnesota's share of money from the KidCare program, established in the 1997 Balanced Budget Act to expand health coverage for children. Stringent federal rules have made it difficult for Minnesota, which has worked for years to provide health coverage for children under MinnesotaCare, to access its \$28.5 million KidCare allocation.

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MMA Launches 'Prescription for a Healthy Baby' Campaign

Parent Education Emphasized

The MMA has launched the "Prescription for a Healthy Baby" Campaign to encourage parents and other caregivers of babies and toddlers to seek parent education and support programs. This campaign stresses the impact of brain development in the first three years of life on intelligence, health, and behavior. The MMA began this effort in response to an MMA resolution adopted by the 1996 House of Delegates and initiated by the MMA Committee on Communications.

Clinics Sent Prescription Pads, Resource Guides

To introduce the campaign, the MMA sent family practice, ob/gyn and pediatric clinics a bright yellow prescription pad with the heading "Prescription for a Healthy Baby," attached to a tent card. Patients may tear off prescriptions that list phone numbers for two major statewide parent education providers, Early Childhood Family Education (ECFE) and MELD (formerly Minnesota Early Learning Design).

MMA staff also sent clinics the third in a series of physician resource guides: "Minnesota Medical Association's Resource Guide for Parents of Babies and Toddlers," which lists some support services for parents and brochures and posters that could be ordered for patient reception areas.

The December issue of *Minnesota Medicine* includes "Bringing Up Baby," an article about research at the University of Minnesota on the complex array of factors that shape the developing brain; "Physicians Prescribe Parent Education;" and the "Physicians' Guide to Support Programs for Parents."

Media Interest Is Strong

St. Paul pediatricians Cynthia Garr, M.D., and Stan Leonard, M.D., appeared on KSTP-TV on December 18 to explain why the MMA launched the Prescription for a Healthy Baby campaign and to talk about the importance of the first few years of life.

Marjorie Hogan, M.D., a Minneapolis pediatrician, talked about the MMA's campaign with host Lorna Benson on "All Things Considered," on Minnesota Public Radio Station KNOW on December 17. Excerpts from that program were broadcast on MPR news on KNOW and KSJN. Hogan was also interviewed by Minnesota News Network, whose programs are broadcast on radio station WMNN and on other stations throughout the state.

Terence Coyne, M.D., a pediatrician, was interviewed on WQPM-radio in Princeton on December 17. As *The Monitor* goes to press, Timothy Komoto, M.D.,

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president of the Minnesota Chapter of the American Academy of Family Physicians, is scheduled to appear on KARE-11 TV's "How Does Your Baby Grow?" on January 20.

Other spokespersons for the campaign include Kent S. Wilson, M.D., MMA president; Joseph Rigatuso, M.D., an East Metro trustee and president of the Minnesota Chapter of the American Academy of Pediatrics; Judith Shank, M.D., MMA president-elect; Thomas L. Peyla, M.D., an MMA alternate delegate to the AMA and a pediatrician; James L. Anderson, M.D., a Northeast trustee and a pediatrician; Raymond G. Christensen, M.D., immediate past president of the MMA and a family physician; Karen Dickson, M.D., a West Metro trustee and a psychiatrist; Barbara Yawn, M.D., a family physician; and Jerome Kwako, M.D., a pediatrician. The list continues to grow. • • • • •

BMP Relinquishes Administrative Role with HPSP

A program that provides a confidential alternative to public disciplinary action for impaired health care professionals has found itself in search of a home.

The Health Professionals Services Program (HPSP) was created by the Legislature to allow numerous health licensing boards to jointly monitor health care professionals with problems of alcoholism, chemical dependency, and mental illness. Since its 1994 inception, the Board of Medical Practice has administered HPSP—setting the program's budget, hiring personnel, and ensuring that the program's direction is in accord with its authority.

Other participating health licensing boards include the boards of chiropractic, dentistry, marriage and family therapy, nursing, pharmacy, podiatry, and social work. HPSP has proven a useful tool for protecting patients from health professionals who may not be able to practice, as the law states, "with reasonable skill and safety"—but for whom, because of disability or illness, public disciplinary action may be counterproductive.

But the Board of Medical Prac-

tice relinquished its administrative role, effective December 1. The state Department of Administration will take over some administrative aspects of the program on a temporary basis, but HPSP is without an administrative board in the long term; thus far none of the participating boards have volunteered to assume responsibility for the program's administration.

Rob Leach, executive director of the BMP, said the board achieved its goals with regard to "getting the program on its feet"—including finding adequate staffing, getting a program manager certified, and securing supplemental funds from the Legislature when the initial budget was found to be inadequate. "I don't think we ever anticipated that we would continue (administering HPSP) in perpetuity," Leach said.

As physicians are among the practitioners with the highest participation in the program, Leach said concerns exist about the perceived potential for conflict of interest. "The Medical Board's close relationship with the program has maybe kept some physicians out of it," he said. "Also, it's kind of hard evaluate your participa-

tion in the program if you're administering it. I don't think we would be able to objectively look at that."

Participation in HPSP is largely voluntary. Health care professionals may self-refer to the program, or a licensing board may require an impaired professional to participate as a condition for avoiding disciplinary sanctions.

An impaired professional may also be referred to HPSP by a colleague. The 1994 law dictates that any person who has personal knowledge that a physician is unable to practice "with reasonable skill and safety" because of disability or illness has the option to file a report either with the BMP or with HPSP. The law also provides that a report made to HPSP will satisfy the reporting requirements for certain health care professionals, such as the reporting requirements of the Medical Practices Act.

As of November 1997, HPSP had an active caseload of 389 health professionals—116 of whom were physicians, and three of whom were residents. HPSP participants are monitored for three years; in recent months, 240 health professionals—including 83 physicians and one resident—completed the program. • • • • •

Tobacco Trial Scheduled to Begin January 20; Industry Documents Posted on Internet

Health and antitobacco activists are eagerly awaiting the start of Minnesota's lawsuit against tobacco companies, slated for trial January 20.

At *Monitor* press time, Ramsey District Judge Kenneth Fitzpatrick appeared increasingly irate with the tobacco industry for improperly hiding sensitive documents behind attorney-client privilege. On December 16, he ordered the release of over 800 documents, which came from the files of the Liggett Group, to attorneys for the state of Minnesota.

Those documents also were subpoenaed by the House Commerce Committee, and were posted on the

Internet at www.house.gov/commerce/TobaccoDocs/documents.html on December 18. They show a strenuous, ongoing effort by the industry to stifle critical scientific findings, cultivate friendly research, and target young people to create new customers.

Minnesota Attorney General Hubert H. Humphrey III announced plans to seek an additional 240,000 documents previously protected by claims of attorney-client privilege.

The state, along with Blue Cross and Blue Shield of Minnesota, is aiming to collect reimbursement for the cost of treating smoking-related diseases. • • • • •

The Monitor

JANUARY 1998

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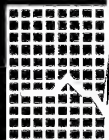
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Hormone Replacement Therapy in Primary Care

A Review

Chad B. Hanna, M.D.

ABSTRACT

Hormone replacement therapy (HRT) is an important component of health care maintenance in the peri- and postmenopausal woman. This review outlines the essentials of HRT with special attention to therapy options. Conclusions are based on data gathered from a Medline search and extensive review of the literature.

Hormone replacement therapy (HRT), the replacement of ovarian hormones in the peri- and postmenopausal patient, remains an ambiguous medical practice. Lack of precise indications and poor or scant data have caused considerable frustration in the primary care setting. Much of the literature has focused on defining both the advantages and life-threatening complications of HRT, and far less on compliance and management issues. This article is a brief literature review of HRT, including indications, contraindications, advantages, disadvantages, and therapy options. (A summary of HRT options appears in table form on page 45.)

INDICATIONS

Thus far, research data have not clearly defined the indications for HRT. The United States Preventive Services Task Force has concluded that there is still insufficient evidence to recommend HRT for all women, but that all women should receive risk/benefit counseling regarding HRT around the time of menopause.¹ The American College of Obstetricians and Gynecologists (ACOG) states that initial HRT should be considered for relief of hot flashes, atrophic vaginitis, and some psychiatric complaints. Long-term therapy may be indicated in postmenopausal women to decrease the risk of heart disease and to prevent osteoporosis.² The American Association of Clinical Endocrinologists also recommends considering HRT for the prevention and treatment of postmenopausal osteoporosis.³ A standard meta-analysis by Grady et al. concluded that HRT

should probably be recommended for women who have had hysterectomies and for those with coronary artery disease or who are at high risk for CAD.⁴ Neither the American College of Cardiology nor the American College of Rheumatology have made definitive comments regarding indications for HRT.

Routine cholesterol level, blood pressure, breast exam, mammography, Pap smear, and pelvic exam prior to initiating HRT are recommended.²

CONTRAINDICATIONS

ACOG lists the following contraindications to HRT.²

- unexplained vaginal bleeding;
- active liver disease;
- chronic impaired liver function;
- recent vascular thrombosis;
- carcinoma of the breast; and
- most cases of endometrial carcinoma.

Relative contraindications include:

- seizure disorders;
- hypertension;
- uterine leiomyomas;
- familial hyperlipidemia;
- migraine headaches;
- thrombophlebitis;
- endometriosis; and
- gallbladder disease.

ADVANTAGES OF HRT

PERIMENOPAUSAL

Symptoms associated with the onset of menopause are highly variable and include irregularity of menses, vasomotor symptoms, mood alteration, and atrophy of the vulva, vagina, and breasts.⁵ Vasomotor symptoms, or

hot flashes, are the most common perimenopausal symptoms reported to physicians. Sixty percent to 75% of women with natural menopause will experience them.⁶ Hot flashes last more than one year in 80% of women who experience them and for more than five years in 25% to 50%.² The relief of hot flashes as well as protection against atrophy of sex organs that estrogen replacement ofers has been well-established.⁵⁻⁷

Estrogen also probably has a role in relieving some of the mild psychological changes at the time of the climacteric. These include memory difficulties, insomnia, anxiety, and irritability.² However, estrogens and progestins may have opposing effects on these symptoms. Higher dosing of estrogen may be beneficial. In one study, 1.25 mg of conjugated estrogen (E) with or without medroxyprogesterone acetate (MPA) was associated with greater energy level, sense of well-being, and better sleep quality than was 0.625 mg E + 5.0 mg MPA.⁷ This psychological action remains controversial.

CARDIOVASCULAR

Cardiovascular disease is the leading cause of death in postmenopausal women.¹ In 1953, Stamler et al. demonstrated that the presence of estrogen was a negative risk factor for the development of coronary atherosclerosis in cockerels.⁸ A standard meta-analysis in 1992 based on data from 32 epidemiologic studies between 1990 and 1991 included a variety of endpoints and indicated that estrogen users had a lower risk for CAD than nonusers. Based on the meta-analysis, it appears that estrogen use reduces risk for CAD about 35% (again considering a variety of endpoints) and risk reduction may be greater in women who already have CAD.⁴ It appears that combined therapy (estrogen and progestin) also significantly reduces risk for both CAD and acute MI, but data are not as abundant as those for estrogen alone.^{4,9} Using retrospective cohort data, Ross et al. found that the relative risk of dying from ischemic heart disease in estrogen users was 0.43 compared with living and dead controls.¹⁰

There are numerous theories regarding estrogen's protective mechanism, the most common being a positive effect on lipoprotein metabolism. Indeed, estrogen use has a favorable effect on HDL/LDL ratio.¹¹ Direct effect on artery muscularis, decreased platelet adhesiveness, and decreased PAI-I and fibrinogen levels are other probable mechanisms.^{4,12}

MUSCULOSKELETAL

Each year, 1.3 million new fractures attributable to osteoporosis occur in the United States.¹ Indeed, a 50-year-old white woman has a 15% lifetime probability of suffering a hip fracture and a 1.5% probability of dying of a hip fracture.⁴ Postmenopausal estrogen replacement decreases the incidence of vertebral fractures and probably hip and Colles' fractures.¹³ Pooled data indicate a relative risk of 0.75 for "ever-users" of estrogen versus nonusers for developing and dying from a hip fracture.⁴ Furthermore, it appears that the minimum effective dose to arrest the process of osteoporosis is the equivalent of 0.625 mg of E per day.¹⁴

A regimen of hormone replacement, calcium supplementation, and exercise is a common approach to primary prevention of osteoporosis.² Although the decision to use HRT must be based on an individual woman's needs, the National Institute of Health Consensus Conference on Osteoporosis has recommended that all postmenopausal women should have total dietary plus supplemental calcium intake of 1000 to 1500 mg per day.¹³

DISADVANTAGES OF HRT

Since the pioneering work was done on the obvious advantages of estrogen replacement in postmenopausal women, it has been well-established that HRT is associated with risks and side effects. The risks are endometrial hyperplasia and carcinoma with unopposed estrogen, and possibly a slightly increased risk of breast cancer and thromboembolic disease. The most bothersome side effect is chronic menstrual bleeding.

ENDOMETRIAL CANCER

The World Health Organization

(WHO) in 1981 reported that endometrial hyperplasia and uterine cancer were probably associated with prolonged use of unopposed estrogens.¹⁵ Earlier, in 1975, Smith et al. had reported an unadjusted relative risk of 4.5 for endometrial cancer among exogenous estrogen users in a retrospective cohort study.¹⁶ Other literature in 1975 suggested that the risk ratio increases with duration of exposure to estrogen replacement.¹⁷ Recently, meta-analysis indicated a relative risk estimate of 8.22 for endometrial cancer in long-term unopposed estrogen use (eight years or more) in pooled data from 1975 to 1991 including 35 studies.⁴ Thus, the concept that estrogen therapy leads to endometrial proliferation, hyperplasia, and finally neoplasia, when not opposed by the addition of progesterone, is widely accepted.¹⁸

Addition of progesterone to the HRT regimen appears to negate the adverse malignant effect on the endometrium, probably by decreasing nuclear estrogen receptors, blocking DNA synthesis, and decreasing cell multiplication.¹⁹ One prospective cohort study showed that relative risk of endometrial carcinoma was 2.2 after three years of unopposed E therapy and 0.9 after three years of combination therapy.²⁰ Another case-control study also showed use of progestin for 10 or more days per month decreased the relative risk for endometrial carcinoma from 3.1 with estrogen alone to 0.9 compared with controls.¹⁹ The standard dosing that appears to offer the protective effect is cyclic dose of 10 mg MPA or continuous dose of 2.5 mg to 5.0 mg.²¹ However, a large controlled trial to assess the most protective regimen has not been performed.

This evidence favoring the protective effect of progesterone on endometrial tissue has led to combined therapy as the standard of care for women with intact uteri.

BREAST CANCER

An observed increased risk of breast cancer among women experiencing early menarche and late menopause has led to heightened concern over replacement of ovarian hormones.²² Data collected between 1980 and

1987 involving case-control studies using healthy comparison groups showed a slightly increased risk of breast cancer in long-term users of estrogen-alone therapy. Addition of progestin does not appear to have a protective effect on the breast.¹⁵ Prospective cohort data from the Nurses' Health Study suggests that current use of HRT (both estrogen alone and combined) modestly increases risk of breast cancer (RR 1.46) for five to nine years and more than 10 years. Long-term past use, however, was not associated with increased risk.²² In another fairly large cohort, long-term estrogen-alone therapy was associated with increased risk of breast cancer (RR 1.7 after nine years), which may have been increased by the addition of progestins (RR 4.4 after six years).²³

However, data on the effect of HRT on breast cancer remains inconsistent. A case-control study in 1995 found that middle-aged women who had ever used HRT were not at increased risk of breast cancer (RR 0.9) and that long-term users (eight or more years) had, if anything, a decreased risk (RR 0.4).²⁴ A meta-analysis of 39 epidemiologic studies since 1970 estimates a relative risk for "ever-users" of ERT of 1.01 compared with women who had never used ERT. Analysis of those who had taken ERT for eight years or more showed a risk of 1.25.⁴

Also, a recent study based on a random sample from the Iowa Women's Study found that in women with no family history of breast cancer, HRT posed no increased risk of developing the disease. Furthermore, even women with a family history of breast cancer lived longer, despite a 30% increased relative risk of breast cancer.²⁵

Strict prohibition of ERT in women with a history of breast cancer remains controversial. A small amount of evidence even suggests more favorable outcomes in women who have tumors associated with estrogen use.²⁶

Obviously, further investigation is needed, including larger trials, especially of longer-term HRT. In light of the conflicting data, it may be logical to assume that if an increased

Table			
<i>Common hormone replacement regimens</i>			
	Unopposed Estrogen*	Sequential Combined	Continuous Combined
	0.625 mg E per day†	0.625 mg E per day†	0.625 mg E per day†
		+	+
Initial		10.0 mg MPA for first or last 10 to 14 days of month [§]	2.5 mg MPA per day
		May increase E to 1.25 mg per day for more severe climacteric symptoms	May increase E to 1.25 mg per day for more severe climacteric symptoms
Improved		May decrease MPA to 5.0 mg per day during cycle for PMS-type symptoms	May increase MPA to 5.0 mg per day for chronic irregular bleeding [#]
		May consider 14-day quarterly MPA cycles (every three months) [¶]	Consider referral for endometrial ablation if bleeding remains problematic with benign endometrium
* Should be reserved for hysterectomized women; otherwise requires annual endometrial biopsy.			
† E=conjugated estrogen (Premarin).			
‡ Or 1.0 mg estradiol (Estrace) or transdermal estradiol (Estraderm) 0.05 mg.			
§ MPA=medroxyprogesterone acetate (Provera).			
Or increase estradiol to 2.0 mg per day or transdermal estradiol to 0.10 mg.			
¶ Data limited.			
# Should first allow four to six months to establish atrophic endometrium.			

risk of breast cancer is associated with HRT, it is probably very small and will usually be outweighed by the benefits.

THROMBOEMBOLIC DISEASE

Unlike oral contraceptive therapy, ERT appears not to be associated with significantly elevated risk of thromboembolic disease. In fact, estrogen doses in ERT may have a favorable effect by decreasing postmenopausal hemostatic factors PAI-1 and fibrinogen.¹² Results based on a small amount of data from uncontrolled studies reporting thrombophlebitis following ERT

have not been supported by controlled trials.^{2,20} Specifically regarding risk of stroke, pooled data suggest no association with ERT.⁴ Results of the Nurses' Health Study record relative risks of 1.09 and 1.27 for current combined and estrogen-alone therapy, respectively.²⁷ Nonetheless, the prudent physician will discontinue ERT in the presence of thrombosis or embolus.

MENSTRUAL BLEEDING

Unfortunately, menstrual bleeding is a major drawback that greatly hinders compliance with estrogen-progesterone combined therapy.²¹

Menstrual bleeding (at least withdrawal bleeding) and fear of cancer are the two most common reasons for discontinuation of HRT.²⁸ One retrospective study of 301 patients on ERT had an overall compliance rate of only 30%.²⁹ In another trial, 15 of 18 women on cyclic HRT dropped out because of withdrawal bleeding, whereas none of the 22 women who had had hysterectomies dropped out.³⁰ A survey distributed by Ferguson et al. found that "the most unfavorable factor for women taking ERT and for premenopausal women was the fact that it would cause them to have periods."³¹

THERAPY OPTIONS

UNOPPOSED ESTROGEN THERAPY (WITHOUT PROGESTIN)

Unopposed estrogen therapy is probably the simplest option, but as noted, also the most dangerous with regard to endometrial histology.¹⁶ In one large trial, estrogen-alone therapy achieved no better rates of amenorrhea than continuous combined therapy.³² In addition, irregular menstrual bleeding often becomes more frequent as this regimen continues. The current standard regarding estrogen-alone therapy is that it should be reserved for women who have had a hysterectomy. If progestin cannot be used by a woman with a uterus, annual endometrial biopsy should be performed, including a baseline sample prior to initiation.²

SEQUENTIAL COMBINED THERAPY

Historically, sequential combined therapy has been the most widely used option. As noted, however, retrospective data indicate that non-compliance with this regimen is high because of menstrual bleeding. About 90% of patients on a cyclic regimen will have a regular withdrawal bleed. Different progestin compounds have been studied to minimize menstrual blood loss, but combinations including levonorgestrel have not made a difference.³³ This regimen remains appropriate for perimenopausal women with climacteric symptoms who continue to menstruate as long as they are using a valid form of birth control.³⁴ In fact, menses usually be-

comes more predictable and less voluminous on sequential HRT.³³ One previously mentioned prospective trial showed approximately an 8% incidence of irregular menstrual bleeding compared with 12% to 22% incidence with continuous combined therapy.³² However, HRT does *not* inhibit ovulation. Low-dose oral contraceptives are a better choice for control of vasomotor symptoms and irregular bleeding in perimenopausal women whose ovulation status is unclear and who are at risk for pregnancy.³⁵

Standard dosing for cyclic therapy includes 0.625 mg E (Premarin) daily, which may be increased to 1.25 mg in the case of more severe climacteric symptoms, plus 10 mg MPA (Provera) for the first or last 10 to 14 days of the month. Alternatively, oral estradiol (Estrace) 1.0 mg up to 2.0 mg or transdermal estradiol (Estraderm) 0.05 mg up to 0.10 mg continuously may be used instead of E. Symptoms associated with the addition of progesterone, besides withdrawal bleeding, include breast tenderness, fluid retention, weight gain, dysmenorrhea, and depression and occur in 5% to 10% of women on combination HRT.⁴ These symptoms may resolve when the MPA dose is reduced from 10 mg/day to 5 mg/day during the cycle.² It is unclear whether the lower dose of MPA is as protective as standard dosing.⁴

Another sequential option that has been investigated is quarterly progestin to improve compliance. Ettinger et al. found that this option offered the same safety profile regarding endometrial hyperplasia, and among 214 women in the study, it was preferred nearly four to one over traditional monthly cyclic regimen. This was despite longer, heavier menses and a higher incidence of unscheduled bleeding. The treatment group received 10 mg MPA/day for 14 days every three months.³⁶ This regimen may be a good option for women wishing to avoid frequent cycles.

CONTINUOUS COMBINED THERAPY

This regimen is becoming more common as compliance advantages are discovered. The safety of this regi-

men has been scantily studied, but it appears to be as safe as cyclic therapy with regard to endometrial histology.³⁷ Long-term trials beyond 10 years have not been performed.

Similarly performed trials have shown that long-term continuous combined therapy is associated with progressively diminishing rates of bleeding as therapy progresses because of the development of a benign atrophic endometrium.³⁷ Approximately two-thirds of women are amenorrheic by six months of therapy, and by one year the rate of amenorrhea approaches 90%.³⁷⁻³⁹ Avoidance of premenstrual-like symptoms may be another compliance advantage.³⁸

As noted, the compliance advantage of this regimen is still only a potential one because high rates of irregular menstrual bleeding and spotting in the early phase of treatment have caused patient frustration. In one study, 17 of 79 women (23%) withdrew by week 25 and another 29 of 79 (39%) withdrew in weeks 26 to 78, leaving only 38% of initial participants. Chronic bleeding was the most common reason for discontinuation, but this still accounted for only 19 of the 46 women who dropped out of the study. Of those who remained in the study, about 80% achieved amenorrhea by completion at 78 weeks. Most women who did not achieve amenorrhea had reported more bleeding episodes early in the trial—between weeks one to 25—which may be of clinical significance in predicting outcomes.⁴⁰ The small number of women completing this trial is symbolic of the scarcity of good data in this area.

Fortunately, one large study comparing bleeding patterns in continuous combined versus sequential HRT does exist. In 1994 Archer et al. studied 1,724 postmenopausal patients randomized at 99 sites for one year; 61% of cycles among those using 2.5 mg MPA and 73% of cycles among those taking 5.0 mg MPA were amenorrheic in the continuous combined group. This compares favorably with the estrogen-only group in whom 76% of cycles were amenorrheic. Not surprisingly, about 80% of women on sequential therapy had

regular withdrawal bleeds, but incidence of irregular bleeding was low (8%). Furthermore, incidence of amenorrhea in the continuous group increased as the trial period progressed. About 40% of the lower-dose MPA group and 50% of the higher-dose group had at least seven consecutive amenorrheic cycles by the end of the treatment period.³²

Although it appears that amenorrhea is more easily established in the higher of two dosing regimens,⁴⁰ data concerning optimal dose of progestin is conflicting. Weinstein et al. suggest that an appreciable difference between 2.5 mg and 5.0 mg of MPA may not exist with regard to irregular bleeding.³⁷ But Magos et al. achieved a 95.1% amenorrheic rate at one year in a small group of patients by increasing progestin doses.³⁸

The currently accepted recommendation for this type of HRT is the equivalent of 0.625 mg of E along with 2.5 mg MPA initially, and up to 5.0 mg after a reasonable amount of time (four to six months) if chronic irregular bleeding remains problematic.²

ENDOMETRIAL ABLATION

A continuous combined regimen of HRT is probably an effective method of treating postmenopausal women who may have been on a cyclic regimen and no longer wish to experience periods. As mentioned, most of these women become amenorrheic by six months and an even greater majority by one year of treatment. Among those who continue to experience bothersome bleeding, in addition to ruling out potentially malignant processes, most trials have demonstrated the effectiveness of increasing the progestin dose.

But what about women who continue to bleed despite such interventions? Recently, Spaulding investigated the relatively common practice of endometrial ablation for refractory bleeding among HRT users. He found that of 162 women who completed the study, 65% were free of bleeding at three months of continuous combined therapy. Twenty-two percent stopped bleeding after an increase in progestin dose from 2.5 mg

MPA to 5.0 mg MPA. This left 13% (21 total) of patients who continued to have any episodes of bleeding. All of those patients underwent endometrial resection and ablation, which largely revealed endometrial polyps, leiomyomas, and adenomyosis. All patients were free of bleeding by the end of the study.⁴¹

CONCLUSION

The main advantages of estrogen replacement are relief of perimenopausal vasomotor symptoms, as well as cardiovascular and skeletal protection. The main disadvantages are increased risk of endometrial carcinoma with unopposed estrogen therapy and persistent regular or irregular menstrual bleeding in combined therapy, which often results in non-compliance. A slight increased risk of breast cancer may exist.

Standard methods of administering HRT to nonhysterectomized women include the equivalent of 0.625 mg conjugated estrogen up to 1.25 mg if vasomotor symptoms remain problematic. This is combined with a progestin, usually cyclic or continuous MPA. In cyclic therapy, 10 mg MPA is added for 10 to 14 days of the cycle and induces regular withdrawal bleeding toward the end of the course. In continuous therapy, 2.5 mg MPA is added daily, and early, irregular menstrual bleeding or spotting can be expected. For most women, bleeding will cease by six to eight months and almost all by 12 months. The dose of MPA can be increased to 5.0 mg per day if no reduction in bleeding is seen by about four to six months.

Endometrial ablation is an option for persistent bleeding, but workup of any change in bleeding pattern or resumption of bleeding once amenorrhea has been established is imperative.

MM

When he did this study, Chad Hanna was a resident physician in the Department of Internal Medicine at the Hennepin County Medical Center. Currently, he is a captain in the U.S. Air Force and chief of Internal Medicine Element, 95th Medical Operations Squadron/SGOMF at Edwards Air Force Base in California.

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Trends in Managed Care Liability

Individuals and states are challenging the federal law that limits quality of care claims against managed care organizations.

Keith J. Halleland, J.D., and Tracey L. Galinson, J.D.

Over the last decade, managed care organizations (MCOs) have reshaped the nation's health care system. Some observers argue that MCOs have become essential players in treatment decisions. As a result of this shift, medical malpractice litigation appears to be moving in a new direction. Lawsuits traditionally brought against physicians for failure to meet standards of care are now also brought directly against managed care organizations. This trend challenges federal law, which historically has limited MCOs' liability in the area of plan administration.

At the heart of the debate is the role of MCOs in the physician-patient relationship. Should MCOs' liability be expanded for alleged interference in medical decisions? Litigation in this area is on the rise, as well as proposed legislation at the state and federal levels seeking to define the nature and extent of MCO responsibility. While it is too early to tell the outcome of the debate, it seems likely that the standard of care for managed care organizations is headed for change as legislators and the courts continue to struggle with the issue.

THE TEXAS HEALTH CARE LIABILITY ACT

On September 1, 1997, Texas enacted the Health Care Liability Act, which allows MCO patients or plan participants to sue their MCO for medical malpractice. More specifi-

cally, the act allows patients to bring claims directly against health insurance carriers, health maintenance organizations, and other managed care entities if those entities fail to meet the ordinary standard of care when making health care treatment decisions. The law essentially applies to MCOs the negligence standard traditionally used against physicians in medical malpractice cases.

Although this law is the first of its kind in the United States, similar legislation is being considered in Arizona, California, Connecticut, Florida, Maryland, Missouri, New Jersey, New York, Rhode Island, Tennessee, and Virginia. The Texas law and others like it could lead to significant changes in patient rights and in the relationships between MCOs and physicians. While these new laws will not prevent physicians from getting sued, they may increase the potential for more complex and protracted litigation in this area. Moreover, the new laws may have an impact on federal health care regulation under the Employee Retirement Income Security Act (ERISA).

THE ERISA DEFENSE

Federal ERISA law regulates all state law claims relating to employee benefit plans. In general, ERISA establishes a national standard for MCOs that administer group health plans and provides legal remedies for people covered by group health plans (plan participants) who file claims for benefits against their plans. ERISA

provides only limited remedies for breach of fiduciary duty and bars or "pre-empts" state law claims that challenge a plan's administration of health care benefits. This ERISA "shield" has proven a strong legal defense for MCOs being sued for "quality of care" claims that implicate plan administration.

The Texas act and others like it may enable plan participants to overcome the "ERISA defense" and bring medical malpractice and similar claims directly against managed health care organizations. Aetna Health Plans is leading the fight against the Health Care Liability Act, arguing that the law improperly extends state law into an area exclusively regulated by ERISA—the administration of group health plans.

AETNA FIGHTS TEXAS ACT

Shortly after the passage of the Health Care Liability Act, Aetna Health Plans of Texas sued the state to block implementation of the new law.¹ Aetna contends that the law is fundamentally at odds with Congress's intention of minimizing the need for employers to administer their health plans differently in each state where they have employees. Aetna argues that Congress intended the regulation of employee benefit plans to be exclusively a federal concern. Consequently, Aetna maintains, the Texas law represents an improper extension of state law into an area exclusively regulated by federal ERISA law. *continued*

The Texas Department of Insurance argues that Aetna, like any other managed care organization, is a treatment provider. The department asserts that regulating a treatment provider is clearly within a state's power and is not subject to federal ERISA law.

The parties' motions are still pending in this case, and no decision has been made regarding implementation of the Texas law. If Aetna is unsuccessful in its argument, more states are likely to pass similar legislation holding managed care organizations accountable for the quality of care a patient receives.

COURTS UPHOLD ERISA PROTECTION

Should MCOs be legally liable for the quality of care a patient receives? The law in this area is still evolving. While MCOs have the authority to deny care or referrals for their plan participants, they have uniformly asserted that they do not make medical decisions, at least when the MCO does not directly employ its physicians. As the following cases illustrate, most courts continue to uphold MCOs' use of the ERISA defense in cases dealing with quality of care claims.

TURNER V. FALLON COMMUNITY HEALTH PLAN, INC.

In *Turner v. Fallon Community Health Plan, Inc.*, the United States Court of Appeals for the District of Massachusetts concluded that ERISA does not provide a remedy for health plan participants who sue their health plans for wrongful denial of benefits.² The plaintiff, Charlotte Turner, was insured by Fallon Community Health Plan Inc., an HMO. In 1991, Turner was diagnosed with breast cancer and underwent surgery, chemotherapy, and radiation. By 1993, however, the conventional treatments had failed, and tests indicated that the cancer had spread. Turner's physician said her "only hope" was a bone marrow transplant. The HMO paid for Turner to be evaluated at several bone marrow transplant institutes, but it ultimately denied coverage of the \$100,000 treatment be-

cause of lack of data showing likelihood of success. Turner died in 1994.

Turner's husband sued the HMO directly under federal ERISA law, claiming that the denial of coverage was not made in good faith and was a breach of fiduciary duty. The court upheld ERISA protection in the case and declined to create a remedy allowing plan participants to sue administrators who fail to provide the benefits due under the plan. The court concluded that ERISA's express remedies signal the courts not to create additional remedies of their own and that changing the type of relief provided under ERISA is a job for the legislature, not the courts. It is clear that in the District of Massachusetts, ERISA law still pre-empts quality of care claims against managed care organizations.

SHEA V. ESENSTEN ET AL.

In *Shea v. Esensten et al.*, the United States Court of Appeals for the District of Minnesota concluded, like the court in *Turner v. Fallon Community Health Plan, Inc.*, that ERISA precludes state law quality of care claims brought against an HMO.³

In this case, Patrick Shea, the plan participant, complained of chest pains and shortness of breath to his primary care physician. Based on Shea's symptoms and medical records, the physician decided that a referral to a cardiologist was unnecessary. Shea later died of heart failure. His wife, Dianne Shea, sued the HMO, claiming the HMO financially rewarded its physicians for giving few referrals to specialists. If her husband had known about these alleged "disincentives," Dianne Shea claimed, he would have sought and paid for a cardiology referral on his own. She further claimed that the HMO had a duty to disclose financial incentives that would affect the quality of care her husband received.

The court determined that ERISA precluded Dianne Shea from bringing a quality of care claim against the HMO, concluding that such a claim would directly affect the way the health plan is administered. The court also remanded to the district court the issue of whether the HMO should be required to disclose how it reim-

bursed the plan's physicians for the patient's medical care. Discovery is still proceeding on the issue of disclosure.

The United States Supreme Court declined to hear Dianne Shea's appeal of the 8th Circuit's decision. ERISA remains the law in Minnesota, precluding quality of care claims against MCOs when the claims relate to the administration of a group health plan.

CONCLUSION

Who should be legally responsible for the quality of care a patient receives? The courts and the legislature continue to struggle with this question. Although a number of states are working to pass legislation in this area, the courts are reluctant to establish a remedy outside the reach of federal ERISA law. In the end, it may be up to Congress to formulate a definitive response to the quality of care issue.

MM

Keith Halleland is a founder and shareholder of Halleland Lewis Nilan Sipkins & Johnson and chair of the firm's affiliated consulting company, Comprehensive Consulting Services. Tracey Galinson is an associate with the firm, specializing in health care and insurance litigation and regulatory compliance.

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2. *Turner v. Fallon Community Health Plan, Inc.*, No. 97-1253 (1st Cir. October 20, 1997).
3. *Shea v. Esensten et al.*, 107 F.2d 625 (8th Cir. 1997).

Sacrificial Love

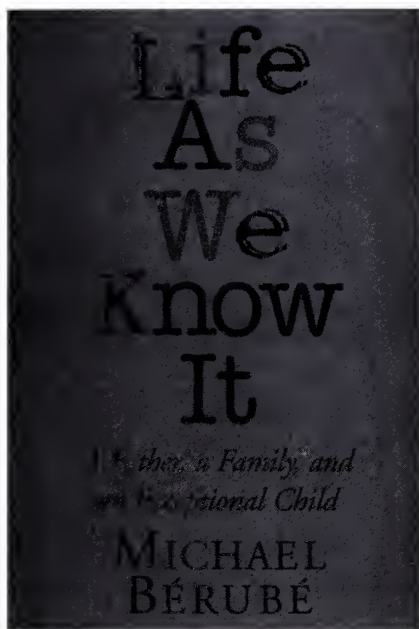
In "Life As We Know It," a father tells an inspiring story about raising a son with Down syndrome, but the reviewer is disheartened by the author's pro-choice arguments.

Reviewed by Steve Calvin, M.D.

The unexpected birth of a son with Down syndrome and the remarkable experience of the boy's first four years of life led Michael Bérubé to write the thought-provoking "Life As We Know It: A Father, a Family, and an Exceptional Child" (Pantheon Books, 1996). Though the lessons Jamie Bérubé's parents learned are applicable to children with many kinds of disabilities, this is an excellent review of the expanding possibilities for those among us with an extra chromosome 21.

Only during the last two decades have courageous parents and therapists refused to accept the self-fulfilling pessimistic prognoses traditionally offered by physicians and psychologists. Pejorative and racist terms like "mongoloid idiot" are now as rare as the pathetic warehousing of those with Down syndrome. With extraordinary efforts by families and the necessary support of the wider community, Jamie and children like him have surprised us all. Their presence enriches society.

Despite this progress, society is still not doing all it can to aid these vulnerable individuals and their families. A professor of English at the University of Illinois-Urbana/Champaign, Michael Bérubé writes skillfully about the challenges occasioned by the birth and development of his son. He describes the difficulties he has faced when choosing and arranging the various types of therapy Jamie requires to reach his full potential. Fortunately for his son, Bérubé is a



tenacious father who rarely takes no for an answer.

Jamie's story is particularly poignant because his older brother, Nick, is at the other end of the bell-shaped intelligence curve. Their father asks probing questions about definitions of intelligence and the values ascribed to those definitions. He acknowledges and, quite transparently, grieves over the inevitable limits Jamie will face.

"Life As We Know It" is more than a superficial treatment of the particular challenges faced by one family. As a cultural critic, Bérubé also takes the reader on a wide-ranging philosophical tour. A signif-

icant but worthwhile effort is required of the reader. The book also addresses weighty and even eternal questions encountered in the day-to-day practice of medicine.

The second chapter, "Humans Under Construction," considers the ethical questions raised by prenatal diagnosis and abortion. Bérubé's critique is valuable even though he reaches conclusions very different from my own. He professes to be more strongly pro-choice after the birth of his son, believing that access to abortion for any reason is fundamental to women's full participation in society. He is particularly critical of the belief that abortion, although legal, is an immoral choice.

I found it incongruous that Bérubé would champion the cause of the disabled while supporting the choice of prenatal elimination of unborn babies with the same disabilities. Given Bérubé's ardent efforts to defend abortion, this book is the literary equivalent of a pro-choice/pro-child bumper sticker. The degree of personal autonomy required to support unrestricted abortion is out of step with a "communitarian ethic," which focuses on the cumulative community impact of our personal decisions and actions. Even though Bérubé exhorts us to recognize our interconnectedness, he cannot see that abortion weakens society's commitment to the disabled.

Bérubé dreads the day when pressure for prenatal diagnosis and abortion could be applied to women



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carrying babies with disabilities. He expresses his fear for Jamie's future in a world run by either Social Darwinists or mean-spirited pro-life puritans. He strives to construct a safe world for Jamie built on a shaky foundation of absolute personal autonomy.

Another flaw in this book is Bérubé's often blatant antipathy toward traditional morality in general and the Catholic Church in particular; his unfair characterizations make this book difficult for people of faith to read.

Bérubé writes that "anyone who's paid attention to the 'political correctness' wars on American campuses knows how stupid the academic left can be. We're always talking about language instead of reality." He points out that although some arguments about words are silly, sometimes words really do matter. The difference in connotation between "retarded" and "disabled," for example, is particularly important to Jamie's long-term outlook. I would also argue that the language of prenatal diagnosis affects the decision to abort a baby. It is easier to support the abortion of a "deformed fetus" than a "disabled unborn baby."

"Life As We Know It" is both motivating and upsetting. Jamie and his family's sacrificial love are an inspiration. Even with its one regrettable blind spot, this book encourages us to resist the cultural currents that threaten to carry us further away from our commitment to care for the most vulnerable among us. **MM**

Steve Calvin is a perinatologist and codirector of the Program for Human Rights in Medicine at the University of Minnesota.



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People and Places Making Medical News

People

HealthSystem Minnesota Names Director

Paul Tolzmann, M.D., was named medical director of HealthSystem Minnesota in December. He will focus on recruiting, mentoring, and building a sense of teamwork among physicians and other health care professionals. Tolzmann has been a family practice physician with Park Nicollet Clinic for eight years and chair of the Family Practice Department for the past two years.

Places

Fairview Teams with Duluth Hospital System

Minneapolis-based Fairview Health System will work with St. Luke's Hospital, a regional hospital system based in Duluth, to help manage Community Memorial Hospital in Cloquet. Fairview and St. Luke's will share responsibility for providing management support to Community Memorial, including creating a business plan, addressing long-term care issues, measuring community needs, and assisting the local physician organization. Fairview and St. Luke's are also planning to develop a new clinic in Virginia, Minnesota, within the year.

Several health care observers expect the relationship to evolve into a merger or acquisition, according to the Minneapolis-based *CityBusiness*. But Fairview and St. Luke's had not discussed such relationships, said Robin Gaustad, Fairview vice president for delivery system development and outreach.

Camp for Kids with AIDS Puts Down Stakes in Minnesota

Camp Heartland, the nation's largest summer camping program for children with HIV and AIDS, is

buying a 75-acre camp outside Willow River, about 85 miles from the Twin Cities just north of Hinckley. For the last four years, the camp rented space at sites across the country. With the help of a loan from the Minnesota Nonprofit Assistance Fund, the camp, which has served more than 1,200 children, raised enough money to buy the Willow River site from the Minneapolis Optimist Club.

Camp founder Neil Willenson, Twins ballplayer Paul Molitor, and his wife, Linda Molitor, kicked off a campaign to raise \$4 million to get the camp ready to open this summer and to convert it for year-round use. Camp Heartland is expected to serve 100 children a week in the summer. The camp carries medical equipment and supplies and trains its counselors how to handle the special needs of children with HIV or AIDS.

Waseca Area Medical Center Joins Mayo Health System

Waseca Area Medical Center became part of Mayo Health System January 1. The hospital and outpatient clinic, now called Waseca Area Medical Center—Mayo Health System, joined a network of clinics and hospitals being developed by Immanuel St. Joseph's in communities near Mankato. Construction of a new outpatient building that will be attached to the hospital is expected to begin this year. Mayo Health System and Immanuel St. Joseph's will fund the new facility and improvements to the hospital.

Rural Hospitals Receive Grants

Eleven rural Minnesota hospitals received grants in November from the state's Rural Hospital Planning and Transition Grant Program, which aims to preserve and improve access to health care in rural areas. The following hospitals were

given awards: Albany Area Hospital, Albany, \$13,000; Lakewood Health Center, Baudette, \$25,000; Northern Itasca, Bigfork, \$15,000; Johnson Memorial, Dawson, \$42,000; Kittson Memorial, Hallock, \$10,000; Minnesota Valley, LeSueur, \$10,000; Long Prairie Memorial, Long Prairie, \$25,000; Mercy Hospital, Moose Lake, \$25,000; Redwood Falls Municipal, Redwood Falls, \$20,000; Lakewood Health System, Staples, \$25,000; and Wheaton Community Hospital, Wheaton, \$40,000.

Socioeconomics

Allina Adds Coverage for All Prescription Drugs

In response to consumer demand for a broader array of pharmaceuticals, Allina Health System's Medica Health Plans is adding coverage for all prescription drugs starting February 1. Medica's coverage is currently limited to a formulary, which will remain in place. Medica members will be able to buy nonformulary prescription drugs with a higher copayment—\$26 or 40 percent of the drug's cost, whichever is greater. Allina also announced that it will increase its standard copayment for prescription drugs from \$9 to \$11, the first hike in eight years.

John Kleinman, M.D., Allina Health System vice president for clinical services, said the move is a response to escalating prescription costs, the proliferation of high-cost drugs that duplicate available medications, and aggressive marketing to consumers by pharmaceutical companies. Kleinman told the *Saint Paul Pioneer Press* that physicians have reported increased pressure from patients for heavily advertised drugs that are not on Medica's approved list. Allina's drug costs have grown

about 110 percent since 1990; average pharmacy costs per member per month have increased from \$84 to \$180.

Kleinman said he expects other health plans to follow Allina's lead. Bloomington-based HealthPartners has a similar formulary plan in development, awaiting approval from the Minnesota Department of Health.

Rates, Trends, Data

State Health Plans Get Thumbs Up

Medicaid and MinnesotaCare enrollees report satisfaction with their managed health care plans, according to a survey conducted by the Minnesota Health Data Institute for the Minnesota Department of Human Services (DHS). The survey shows that on a scale of 0 to 10, enrollees consistently gave scores above 8 to their physicians, the quality of care they received, and their managed care plans overall.

"We conducted the study to see how well the health plans we contract with are serving our clients," said Mary Kennedy, state Medicaid director and DHS assistant commissioner of health care. "We wanted to measure both quality of care and overall satisfaction with the health plan itself, from the consumer's point of view. Overall, our clients are telling us their health plans are doing a good job."

The 6,564 respondents gave high scores for doctors' communication with patients, courtesy, respect and helpfulness of medical office staff, and ease of finding a doctor or nurse they liked. Lowest scores were for efficiency and helpfulness of health plan customer services, waiting time, and encouragement to exercise and eat healthy meals.

Another recent study showed that Medicare recipients in Minnesota are more loyal to their HMOs than in any other state except Hawaii. A national study of HMO dropout rates found that 4.2 percent

of elderly Minnesotans dropped out of their managed care plans in 1996, compared with a low of 2.7 percent in Hawaii and a high of 31.6 percent in the district of Columbia. Plans with lower turnover rates typically have been in the Medicare system longer and have larger enrollments.

The study looked at HealthPartners and Medica, which together had more than 57,000 Medicare recipients enrolled in 1996.

Stearns County Women Live Longest

Women in Stearns County, Minnesota, live an average of 83.5 years—longer than women anywhere else in the country, according to a report by a Harvard University scientist. Many counties in the Upper Midwest fared well in the study of life expectancies for men and women. For women, nine of the top 10 counties for longevity were in Minnesota, Iowa, or South Dakota. For men, two of the top 10 counties—Steele and Olmsted—were in Minnesota. The researcher, Christopher Murray, studied 1990 data.

Experts on aging were not surprised by the report, since life expectancy is high in Minnesota compared with the rest of the country. But they couldn't say exactly why Stearns County ranked first. "There's no magic in the water," said Donna Walberg, director of the Central Minnesota Council on Aging, in a *Saint Paul Pioneer Press* article. She noted that St. Cloud, the largest city in Stearns County, is a fast-growing area for seniors. Other observers attributed the results to the county's largely white population—white women have the highest life expectancy—as well as the relatively stable, rural lifestyles of the population, good health care, and good education.

In stark contrast to the Stearns County women, men in inner cities and on Indian reservations live about as long as men in such developing countries as India and

Bolivia. Male Native Americans in some South Dakota counties had a life expectancy of just 56.5 years, and for black men living in Washington, D.C., the number was 57.9 years.

As National Uninsured Rates Rise, Minnesota Holds Steady

An increasing number of American workers are choosing not to buy the health care coverage offered by their employers, according to a study published in *Health Affairs* in November. In the last decade, the number of Americans who decided not to enroll in their employers' health plans more than doubled, from 2.6 million in 1987 to 6 million in 1996. During the same time, premiums rose by 90 percent—four times the increase in wages.

The Minnesota sample in the survey was too small to draw accurate conclusions about the state's rate, said George Hoffman of the Minnesota Department of Human Services. Since 1990, however, two surveys have targeted Minnesota's uninsured rate, finding that it dipped from 6.1 percent in 1990 to 5.5 percent in 1995. At the same time, the national uninsured rate climbed from about 13 percent to 15 percent. Minnesota's rate has remained stable for several reasons, experts say, including the MinnesotaCare program and the state's strong economy and low unemployment rate.

AIDS Is Spreading Faster Than Estimated

Even as the number of new AIDS cases is declining in the United States and Western Europe, the pandemic is spreading throughout the rest of the world much faster than previously thought, according to a new report from the World Health Organization. Epidemiologists now think that 16,000 people are becoming infected with HIV every day, nearly double the previous estimate of 8,500.

Worldwide, more than 30 million people are HIV-positive or have AIDS. The United Nations

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estimates that 2.3 million people died of AIDS in 1997, a 50 percent increase over 1996.

The revised numbers are higher because of the increasing rate of transmission and better data on the disease in many developing coun-

tries, where more than 90 percent of new infections occur. The number of new AIDS cases in the United States declined in 1996 and 1997.

AIDS Ebbs in Minnesota, Except among Minorities and Women

The number of AIDS deaths in Minnesota, as well as the number of people who are HIV-positive and who develop AIDS, is decreasing each year, according to the state Health Department. But AIDS is not declining among minorities and women.

State health officials say that fewer cases of AIDS among people who engage in male-to-male sex and vastly improved drug treatment have resulted in an ebbing of the epidemic. During the first 10 months of 1997, Minnesota had 64 deaths from AIDS, well below the total of 180 for 1996. But AIDS is increasingly affecting women and minorities, most of whom contract HIV from heterosexual sex or intravenous drug use.

Infant Mortality Rate Drops to All-Time Low

The infant mortality rate in the United States dropped to an all-time low in 1996, researchers reported in the December 1 issue of *Pediatrics*. At the same time, life expectancy for newborns reached an all-time high of 76.1 years. Nationally, infant mortality reached an all-time low of 7.2 deaths per 1,000 births in 1996. In 1995 the rate was 7.6; 6.3 for whites and 15.1 for blacks.

The same improvements are reflected in statistics compiled by the Minnesota Department of Health for 1995, the last year for which figures are available. In Minnesota, the 1995 infant mortality rate was 6.7 deaths per 1,000 live births. The rate was 6 for whites and 17.6 for blacks.

Researchers from Johns Hopkins University and the National Center for Health said the national statistics indicated that more pregnant women are getting prenatal care, fewer are smoking, and advanced technology appears to be helping more premature and low birthweight babies survive.

Cancer Deaths for Women Increase

Cancer deaths for women increased between 1990 and 1995, apparently because of higher rates of smoking. Cancer of the trachea, bronchus, and lung overtook breast cancer as a killer of women in Minnesota, according to a study by the state demographer's office. While death rates from all cancers have fallen for men, they have increased for women. The overall death rate for women also increased in the first half of this decade, while the overall death rate for men dropped.

Health experts said the rise in women's lung cancer rates is due to an increase in smoking among women a generation ago. While no figures on the smoking histories of Minnesota women are available, the report noted that "the current generation of older women probably smoked more than previous generations, and they are paying for it in higher rates of lung cancer."

Medical Research

'U' Researchers Develop Gene Therapy for Leukemia

University of Minnesota scientists have developed a gene therapy for chronic myelogenous leukemia (CML), one of the deadliest cancers. The new treatment combines bone marrow transplantation with genetic engineering to provide resistance to chemotherapy and to prevent any residual cancer cells from reproducing. Catherine Verfaillie, M.D., associate professor of medicine and the lead researcher on the project, said the therapy has been safe and effective in laboratory mice. The research appeared in the December 15 issue of the journal *Blood*. Trials for the gene therapy will take place this year.

The only cure for CML, which strikes about 7,000 Americans annually, is a bone marrow transplant. The new therapy is designed to allow doctors to give CML patients chemotherapy almost indefinitely after a transplant, until

all traces of cancer are gone, to avoid the relapses that patients currently experience.

The research team created a gene sequence that stops stem cells from producing leukemia-causing proteins and another gene sequence

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Benefits of Hormone Therapy Outweigh Risks, Study Suggests

Women with a family history of breast cancer who use hormone replacement therapy live longer than those who do not use it, even though it might increase the chance that some of those women will develop breast cancer, according to a study by members of the University of Minnesota Cancer Center. The study, published in the December 1 issue of the *Annals of Internal Medicine*, also confirmed previous observations that estrogen therapy poses no increased risk of breast cancer for women with no family history of the disease.

The use of hormones after menopause has been controversial because of fears of an increased risk of breast cancer. But the research team, led by Thomas Sellers, M.D., associate professor of epidemiology, found that hormone replacement therapy protected women from heart disease, stroke, and other forms of cancer—all diseases more likely to kill than breast cancer.

"Current clinical guidelines for women with a family history of breast cancer include a recommendation that they avoid use of exogenous estrogen," Sellers said. "We found that women who used hormone replacement therapy to treat menopause or to avoid osteoporosis lived longer than those who did not. We suggest physicians and patients consider these potential benefits from hormone replacement therapy, in addition to the possible risk of developing breast cancer."

Implantable Defibrillators Outdo Drugs in Study

Implantable cardiac defibrillators are far more effective than drug

therapy as "first-line" therapy for life-threatening arrhythmias, according to researchers at the Mayo Clinic. Thousands of Americans who die each year of sudden cardiac death could be saved if the \$20,000 defibrillators were implanted in their shoulders or chests. The study, published in the November 27 *New England Journal of Medicine*, found that patients equipped with the high-tech devices had a 39 percent lower death rate the first year and a 27 percent lower death rate the second year compared with patients treated with drugs designed to control ventricular arrhythmias.

Because the evidence was so convincing, researchers urged doctors to offer implantable defibrillators as first-line therapy.

"The \$20,000 or \$25,000 sounds expensive, but it's about the price of a new car," said Marshall Stanton, M.D., a Mayo Clinic electrophysiologist, in a *Star Tribune* article. "Some people trade in cars every three years. The batteries in an implantable defibrillator last from seven to nine years."

Innovations

Pig-Tissue Heart Valves Get FDA OK

St. Jude Medical Inc. and Medtronic Inc., market leaders in mechanical heart valves, have both received FDA approval for a heart valve made from pig tissue. The new tissue valves do not use stents to help the valve keep its form. The stentless valves allow greater blood flow and are designed to last longer than earlier-generation tissue valves. The U.S. tissue valve market is estimated at \$150 million.

Mechanical valves last longer than tissue valves, which must be replaced every 10 to 12 years, but they also require the use of anti-coagulant drugs. Patients with tissue valves, in contrast, often do not need anticoagulant therapy. MM

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JANUARY 1998

Jan. 12-16 **Bone and Soft Tissue Tumors: A Multidisciplinary Approach** Mayo Foundation; Ihilani Resort, Oahu, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jan. 19-23 **Continuing Challenges in Hematology, Oncology, and Hematopathology** Mayo Medical Laboratories; The Silvertree Hotel, Snowmass, CO. CONTACT: Julie McAdams, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

Jan. 28-31 **Second Annual Postgraduate Course in Ob/Gyn: Avoiding the Traps in Obstetrics and Gynecology** Hennepin County Medical Center; Rancho Bernardo Inn, San Diego, CA. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

Jan. 30 **1998 Pediatrics Conference** St. Mary's/Duluth Clinic Health System; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Diane Torvick, 400 East Third Street, Maildrop 5AV2ME, Duluth, MN 55805.

FEBRUARY 1998

Feb. 6-7 **Fourth Annual Winter Conference** Minnesota Academy of Family Physicians; Arrowwood-A Radisson Resort, Alexandria, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426-1201; 612/542-0130 or 800/999-8198.

Feb. 26-28 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 27-Mar. 1 **Current Concepts of Erectile Dysfunction: Diagnosis and Treatment** Mayo Foundation; Caribe Royale Resort Suites, Lake Buena Vista, FL. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1998

Mar. 8-11 **Neurology in Clinical Practice** Mayo Foundation; Silvertree Hotel and Wildwood Lodge, Snowmass Village, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-13 **Selected Topics in Internal Medicine** Mayo Foundation; Maui Prince Resort, Maui, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 20-21 **Advanced Life Support in Obstetrics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

Feb. 17-20 **Infectious Diseases** MeritCare Health System; Grouse Mountain Lodge, Whitefish, MT. CONTACT: Cheri Rodenburg, MeritCare Critical Care Services, 720 Fourth Street North, Fargo, ND 58122; 800/437-4010, ext. 6913.

Mar. 18 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

June 23 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Mar. 29-Apr. 3 **Advanced Management Program for Healthcare Executives** University of Minnesota Carlson School of Management and Mayo Clinic; Leighton Auditorium, Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

A P R I L 1 9 9 8

Apr. 6-8 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; Scottsdale Princess Resort, Scottsdale, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 16-18 **Fractures and Dislocations of the Wrist, Elbow, and Shoulder** Mayo Foundation; Pointe Hilton Resort on South Mountain, Phoenix, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 17 **Depression and Mood Disorders: Treating Today's Woman** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

April 23-24 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

M A Y 1 9 9 8

May 5-8 **Fifth International Surgical Pathology Symposium** Mayo Medical Laboratories; Munich, Germany. CONTACT: Kathy Bates, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; E-mail: Kbates@mayo.edu, fax 507/284-4542, fax on demand 800/263-6296 or 507/282-0461.

May 15 **Medical Management of the Surgical Patient** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

May 15-16 **John I. Coe Symposium and MSP Meeting (Pathology)** Hennepin County Medical Center; Radisson Hotel South, Bloomington, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

May 22 **Poisonous Mushrooms** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

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May 30 **Critical Care: A Team Approach** Mayo Foundation; Mayo Clinic, Phillips Hall, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

J U N E 1 9 9 8

June 17-20 **62nd Annual Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota Medical School Department of Surgery; Willey Hall, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 800/776-8636.

S E P T E M B E R 1 9 9 8

Sept. 11-13 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center; Radisson Arrowwood, Alexandria, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

Sept. 16-19 **First National Conference on Infanticide: Asphyxiation, Shaken Baby, and Neglect** Hennepin County Medical Center; St. Paul Radisson, St. Paul, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

Sept. 18 **Annual Contemporary Issues in Hemodialysis** Hennepin County Medical Center; Sheraton Midway Hotel, St. Paul, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

O C T O B E R 1 9 9 8

Oct. 1-2 **Annual Forensic Science Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

N O V E M B E R 1 9 9 8

Nov. 19-21 **Annual Orthopaedic and Trauma Seminar** Hennepin County Medical Center; Minneapolis Convention Center, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.



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Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Physician Opportunity: Minneapolis/St. Paul, Duluth, and Moorhead, Minnesota; MD wanted for part-time hours in multidisciplinary office. All inquiries to Integrated Health-Care Services, doctor's private line, 612/386-6908. (1/98-R)

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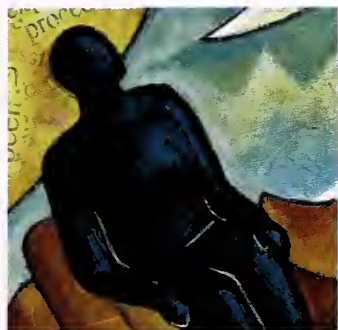
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Minnesota Medicine

Published monthly by the Minnesota Medical Association



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Cover illustration by Sean Kane.

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Attuned to Our Patients

In my father's time, talking with the patient was the biggest part of medicine, for it was almost all there was to do. Today, with the advance of medicine's various and complicated new technologies there is less time for talking.

—Lewis Thomas



Remember the telephone game? The first person in a circle whispers a message to the next person, who passes the same message to the next. The message travels the circle by word of mouth and by the time it returns to its

communication are compelling. Patients who understand their treatment do better medically. Patients who know that their doctor listened and explained rarely sue. Doctors who forge solid bonds with their patients are happier with their work.

The ways to improve doctor-patient communication are endless. Innovative print or online public medical information like that provided by Mayo HealthQuest (see Face to Face profile, page 6) reaches millions. But the most important vehicle is the one that reaches one patient at a time. And polishing this communication is the toughest. For doctors, it means making eye contact and avoiding jargon. It means being attentive to your word choice and facial expression because what patients hear is more than words. It means understanding that your 15-minute conversation may be the most important event in a patient's week. And, in the spirit of good medicine, it means analyzing each day to see if you can improve how you relate to patients.

Methods to teach doctor-patient communication are embryonic. As described in our cover story, teaching human lessons through literature and patient interviewing through videotaping is a start. But the lessons aren't all simple. What may be most difficult to teach is attitude. An open mind and unbiased approach are crucial for perceptive doctors. If the patient is a "crock until proven otherwise," the physician won't recognize significant chest pain. If doctors think they know the diagnosis from the patient's first sentence, they'll miss half the history and physical. And if they let their personal dislike or disapproval of patients color their interactions, communications will be distorted in both directions.

Listening and talking to patients is a tall order and, at times, seems thankless. But the rewards of human contact enjoyed by Lewis Thomas's father are real. Besides, none of us wants one of our patients to be at the end of the telephone game circle, getting the wrong message.

Good listening is key to a good connection. Pass it on.

—Charles R. Meyer, M.D., Editor-in-Chief

.....
"The conversation between doctor and patient is the pivotal cog in the complex medical practice machine."

creator, it frequently suffers from tortured translation and comic corruption. This silly parlor game encapsulates the pitfalls in human communication that plague daily life and that also subvert the therapeutic connection between doctor and patient. Whether doctors and patients can do anything to keep their messages straight is the topic for this month's *Minnesota Medicine*.

The conversation between doctor and patient is not a game. It's the pivotal cog in the complex medical practice machine. If it fails, modern surgery and miracle drugs are more likely to fail, too. Yet doctor-patient communication in the technology age has been neglected. Medical students and residents spend harried and hair-raising hours stuffing medical knowledge into their heads and practicing procedures, while the fundamentals of talking to patients are supposed to get transmitted by osmosis or mimicry.

The barriers to doctor-patient communication, highlighted in this month's cover story (page 14), are protean. Physicians have too little time, too many preconceptions about certain patients, and too many long words. Patients have too much pain, too many expectations of medicine, and too much fear. As a result, too much important information gets lost.

The reasons to improve doctor-patient

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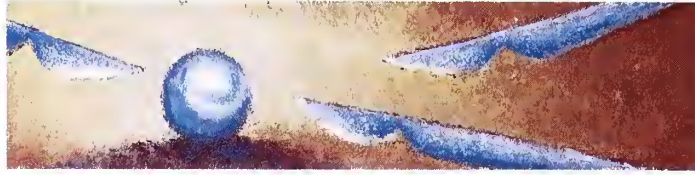
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Assessing Nasal Patency in Neonates

Rolf R. Engel, M.D., Richard C. Lussky, M.D., and Raul F. Cifuentes, M.D.

One in 5,000 to 10,000 infants is born with choanal atresia. The infants typically present shortly after birth with respiratory distress, cyanosis, and apnea that is relieved by crying or mouth breathing. If there is unilateral involvement, the symptoms may include stridor and wheezing secondary to increased airway resistance.

The recommended diagnostic approaches include either 1) inducing respiratory distress by occluding the mouth and then each nostril in succession; 2) closing the mouth and looking for a stream of air with a piece of cotton or tissue paper; or 3) more commonly, attempting to pass either a No. 6 or No. 8 Fr feeding tube or suction catheter through the nares into the pharynx.¹ The last method can be traumatic and can subsequently lead to nasal congestion and feeding problems during the neonatal period. Alternatively, some physicians have suggested attempting direct visualization with an otoscope or instilling methylene blue into the nares and watching for its passage into the oropharynx.² Neither of these methods has been proven very accurate.

The majority of infants can be spared these invasive tests by simply checking for condensation on the convex side of a metal spoon held in front of the nose (see the figure). If there is adequate lighting and the shiny metal surface is below body temperature, it is possible to observe two

discrete areas of condensation with advancing and then receding margins during exhalation and inhalation, respectively. If condensation is observed, choanal atresia and other causes of nasal obstruction can be ruled out. In a warm isolette or on warm days, it

surgical repair. In the interim, an oral airway will maintain airway patency.

Choanal atresia has a 2:1 female-male ratio. It is unilateral in half of the cases, with the right side most commonly affected. Approximately 90 percent of



Figure

may be necessary to cool the spoon in a refrigerator just before testing for condensation. This simple test can also help parents and health professionals determine the efficacy of bulb suctioning done to eliminate nasal mucous.

If condensation is not noted in a symptomatic infant, a CT scan is recommended to definitively diagnose choanal atresia before

cases are osseous in origin, and the remaining 10 percent are membranous. Especially in cases of bilateral involvement, choanal atresia is frequently associated with major congenital anomalies, including the CHARGE association, tracheoesophageal fistula, Apert's disease, and Treacher Collins-Franceschetti syndrome.³

We also have extensively used this simple test in our newborn ICU to assess exhaled air for

carbon monoxide content as a measure of bilirubin production and hydrogen content as an indicator for malabsorption.

Rolf Engel is medical director of the Newborn ICU at Hennepin County Medical Center in Minneapolis and an associate professor of pediatrics at the University of Minnesota. Richard Lussky is assistant medical director of HCMC's Newborn ICU, an assistant professor of clinical pediatrics at the University of Minnesota, and a member of the Minnesota Medicine Advisory Committee. Raul Cifuentes is associate medical director of HCMC's Newborn ICU and an assistant professor of pediatrics, University of Minnesota.

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Red Eyes and Thimerosal Sensitivity

Barbara P. Yawn, M.D., M.Sc.

Not all contact solutions are the same. Some contain thimerosal, a mercury-based stabilizer. Mercury sensitivity is not uncommon and causes red, irritated eyes that may easily be mistaken for conjunctivitis, even by an ophthalmologist. Remember to ask your red-eyed contact wearers to check the ingredient labels on their solutions. Most will state the solution contains no thimerosal. An unrecognized thimerosal sensitivity could turn a satisfied contact wearer into a glasses-dependent grump. I am happy to be wearing my contacts again.

Barbara Yawn is a family physician and director of research for the Olmsted Medical Center in Rochester, Minnesota, and a member of the Minnesota Medicine Advisory Committee.

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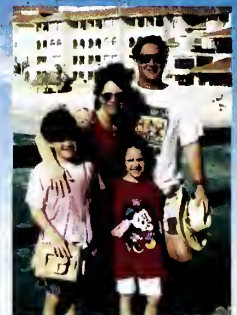
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Mayo Launches Self-Care into the Information Age

As medical director of Mayo HealthQuest, Dr. Philip Hagen must consider page composition, color, and copy when communicating with patients worldwide.

B y D e b o r a h S u g e r m a n

For Philip Hagen, M.D., patient communication means more than taking a patient history; font size, color, and copy are high on his list of considerations. As medical director of Mayo HealthQuest, he merges expertise in written communication, preventive medicine, public health, and technology to provide patients with self-care information—both online and off the press.

Mayo HealthQuest is Mayo Clinic's ambitious new health information initiative aimed at working adults and their families. The project consists of three components: a reference book, a newsletter, and an online service provided in combination with Mayo's existing health care helpline (nurseline). It joins the extremely popular *Mayo Clinic Health Letter*, the "Mayo Clinic Family Health Book," and numerous other print and multimedia publications Mayo produces to deliver accurate, practical health information worldwide.

Hagen, assistant professor at Mayo Medical School and consultant in Mayo's Department of Internal Medicine, Preventive and Occupational Medicine Division, is a natural for the project. He harbors a not-so-secret passion for computers and technology and has a background in preventive medicine. In addition, he brings with

<http://www.mayo>

him seven years' experience as associate editor of the Mayo Clinic Health Letter. But despite some commonality in subject matter, the Health Letter and the HealthQuest newsletter reach different audiences, which meant creating an entirely new publication. "We're learning as we go along," Hagen admits.

The new eight-page newsletter, designed to deliver practical information on subjects ranging from stress management and family concerns to workplace issues and safety, has colorful illustrations and eye-catching type. Articles are kept short, and bullet-style sidebars and checklists are plentiful.

Hagen had similar goals for the "Guide to Self-Care" handbook. At 250 pages, the soft-cover guide is more succinct and less hefty than the encyclopedic "Mayo Clinic Family Health Book."

"There were other good guides on the market," says Hagen. "We had to figure out how to make ours better." So Hagen and his team of editors surveyed clinics to compile the top 250 reasons for patient visits, insurance companies to determine their most costly claims, and businesses to find the most common reasons for employee absence and other work-related problems. "We tried to come up with the top 150 conditions that have a self-care component," Hagen explains.

Mayo HealthQuest differs from previous ventures in that it is targeted to the workforce; businesses can purchase its materials as a benefit for their employees. Thus far, purchasers have included government agencies, insurance companies, businesses, and managed care organizations. Although creating targeted materials is not new for Mayo, the opportunities created by computer technology are. For instance, Mayo customizes the newsletter for businesses by including their logos or even articles of special interest to their employees.

On the Internet the possibilities become truly limitless. Mayo's Web site, Mayo Health O@sis, offers articles, a library, resource guides, and more. And HealthQuest Online, a subscription service focusing on wellness, is functioning in prototype and will be ready for release in April. The service will include an individual health-risk appraisal and a variety of health and wellness tools related to such behaviors as eating habits and exercise.

Hagen has long been interested in prevention and public health, thanks to the influence of his physician father, whom Hagen calls an "early adapter of healthful trends," such as low-cholesterol diets and seat-belt use. When Hagen and his six siblings were growing up in Austin, Minnesota, his father installed seven additional seat belts in the family station wagon.

Hagen's penchant for pursuing several interests simultaneously was already evident during his premed years at Cornell College in Iowa. "The premed program was lockstep, very science-oriented," he recalls. "I needed something else, to use another corner of my brain." So he obtained a double major in biology and philosophy. His decision to specialize in preventive medicine crystallized at Mayo Medical School when he read that there was a projected deficit of practitioners in that specialty. The program dictated that he obtain dual certification in internal medicine

HAGEN continued on page 49



PHOTOGRAPH COURTESY OF MAYO CLINIC

health.org/

Doctor,

When, in the summer of 1989, I moved from Connecticut to Cambridge, Massachusetts, I found that I had difficulty urinating. I was like Portnoy, in “Portnoy’s Complaint,” who couldn’t fornicate in Israel. I had always wanted to live in Cambridge, and the thought passed through my mind that I couldn’t urinate because—like Israel for Portnoy—Cambridge was a transcendent place for me.

When my inhibition persisted, I began to think about a doctor, and I set about finding one in the superstitious manner most of us fall back on: I asked a couple I knew for a recommendation. To be recommended, for whatever unreasonable reasons, gives a doctor an aura, a history, a shred of magic. Though I thought of my disorder as a simple matter—prostatitis is common in men of my age—I still wanted a potent doctor.

I applied to this particular couple for a recommendation because they are the two most critical people I know: critics of philosophy, politics, history, literature, drama, music. They are the sort of people for whom information is a religion, and the rigor of their conversation is legendary. To talk with them is an ordeal, a fatigue of fine distinctions, and I wanted a doctor who had survived such a scrutiny.

They could only give me the name of their internist, who referred me to a urologist. The commendation was diluted, but it was better than none, so I made an appointment to see the urologist in a local hospital. The visit began well. The secretary was attractive, efficient, and alert. She remembered my name. I was shown into a pleasant office and told that the doctor would be with me in a few minutes.

While I waited, I subjected the doctor to a preliminary semiotic scrutiny. Sitting in his office, I read his signs. The diplomas I took for granted; what interested me was the fact that the room was furnished with taste. There

By Anatole Broyard

were well-made, well-filled bookcases, an antique desk and chairs, a reasonable Oriental rug on the floor. A large window opened one wall of the office to the panorama of Boston, and this suggested status, an earned respect. I imagined the doctor taking the long view out of his window.

On the walls and desk were pictures of three healthy-looking, conspicuously happy children, photographed in a prosperous outdoor setting of lawn, flowers, and trees. As I remember, one of the photographs showed a sailboat. From the evidence, their father knew how to live—and by extension, how to look after the lives of others.

Soon the doctor came in and introduced himself. “Let’s go into my office,” he said, and I realized that I had been waiting among someone else’s effects. I felt that I had been tricked. Having already warmed myself to the first doctor, I was obliged to follow this second man, this imposter, into another office, which turned out to be modern and anonymous. There were no antiques, no Oriental rug, and no pictures that I could see.

From the beginning, I had a negative feeling about this doctor. He didn’t seem intense enough or determined enough to prevail over something powerful and demonic like illness. He had a pink, soft face and blue eyes, and his manner was hearty and vague at the same time, polite where politeness was irrelevant. He reminded me of a salesman with nothing to sell but his inoffensiveness.

I didn’t like the way he spoke: it struck me as deliberately deliberate, a man fixed in a pose, playing doctor. There was no sign of a tragic sense of life in him that I could see, no furious desire to oppose himself to fate. I realized, of course, that what I was looking for was

Talk to Me

A writer conjures an image of a physician as
one who will treat his body—and his soul.

extravagant, that I was demanding nothing less than an ideal doctor, yet isn't that what we all want?

In the end, it didn't matter whether my reading of this particular man was just or unjust—I simply couldn't warm up to him. Choosing a doctor is difficult because it is our first explicit confrontation of our illness. "How good is this man?" is simply the reverse of "How bad am I?" To be sick brings out all our prejudices and primitive feelings. Like fear, or love, it makes us a little crazy. Yet the craziness of the patient is part of his condition.

I was also aware of a certain predisposition in myself in favor of Jewish doctors. I thought of them as the troubleshooters—the physicians, lawyers, brokers, arbiters, and artists—of contemporary life. History had convinced them that life was a disease. My father, who was an old-fashioned Southern anti-Semite, insisted on a Jewish doctor when he developed cancer of the bladder. A Jewish doctor, he argued, had been bred to medicine. In my father's biblical conception, a Jew's life was a story of study, repair, and reform. A Jewish doctor knew what survival was worth, because he had had to fight for his. Obligated to treat life as a business as well as a pleasure, Jews drove hard bargains. To lose a patient was bad business. In his heart, I think my father believed that a Jewish doctor was closer to God and could use that connection to "Jew down" death.

This other, all-too-human doctor took me into an examination room and felt my prostate. It appeared to me that he had not yet overcome his self-consciousness about this procedure. Back in his office, he summed up his findings. There were hard lumps in my prostate, he said, which suggested tumors, and these "mandated" further investigation. He used the word "mandate" twice in his summary, as well as the word "significantly."

But he was the only urologist I knew in Cambridge, and so, a few days later, I allowed him to perform a cystoscopy, a procedure in which a small scope was inserted through my urethra up to my prostate and bladder. During surgical procedures, doctors wear a tight-fitting white cap, a sort of skullcap like the one that Alan Alda wears in "M*A*S*H." To this, my doctor had added what looked like a clear plastic shower cap, and the moment I saw him in these two caps, I turned irrevocably against him. He wore them absolutely without inflection or style, with none of the jauntness that

**"I was demanding
nothing less than an ideal
doctor, yet isn't that what
we all want?"**

usually comes with long practice. He wore them like an American in France who affects a beret without understanding how to shape or cock it. To my eyes, this doctor simply did not have the charisma to overcome or assimilate those caps, and that finished him off for me.

I want to point out that this man is in all likelihood an able, even a talented doctor. Certainly, I'm no judge of his medical competence, nor do I mean to criticize it. What turned me against him was what I saw as a lack of style. I realized that I wanted my doctor to have style—which I think of as a dash of magic—as well as medical ability. It was like having a *lucky* doctor. I've described all this—a patient's madness—to show how irrational such transactions are, how far removed from any notion of dispassionate objectivity. To be sick is already to be disordered in your mind as well. Still, this does not necessarily mean that I was wrong to want to change doctors: I was simply listening to my unconscious telling me what I needed.

Now that I know I have cancer of the prostate, the lymph nodes, and part of my skeleton, what do I want in a doctor? I would say that I want one who is a close reader of illness and a good critic of medicine. I secretly believe that criticism can wither cancer. Also, I would like a doctor who is not only a talented physician but a bit of a metaphysician too, someone who can treat body and soul. I used to get restless when people talked about soul, but now I know better. Soul is the part of you that you summon up in emergencies. You don't need to be religious to believe in the soul or to have one.

My ideal doctor would be my Virgil, leading me through my purgatory or inferno, pointing out the sights as we go. He would resemble Oliver Sacks, the neurologist who wrote "Awakenings" and "The Man Who Mistook His Wife for a Hat." I can imagine Dr. Sacks *entering* my condition, looking around at it from the inside like a benevolent landlord with a tenant, trying to see how he could make the premises more livable for me. He would see the genius of my illness. He would mingle his daemon with mine; we would wrestle with my fate together. Inside every patient, there's a poet trying to get out. My ideal doctor would "read" my poetry, my

literature. He would see that my sickness has purified me, weakening my worst parts and strengthening the best.

To most physicians, my illness is a routine incident in their rounds, while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity. I don't ask him to love me—in fact, I think the role of love is greatly exaggerated by many writers on illness. Of course you want your family and close friends to love you, but the situation shouldn't become a hunting season for love, or a competition, a desperate kiss before dying. To a critically ill person, love may begin to resemble an anesthetic. In a novel by Joy Williams called "State of Grace," a character asks: "What can be beyond love? I want to get there." The sick man has got there: he's at a point where what he wants from most people is not love but a spacious, flaring grasp of his situation, what is known in the literature of illness as "empathetic witnessing." The patient is always on the brink of revelation, and he needs someone who can recognize it when it comes.

Just as I see no reason for my physician to love me, I would not expect him to suffer with me either. On the contrary, what would please me most would be a doctor who *enjoyed* me. I want to be a good story for him, to give him some of my art in exchange for his. If a patient expects a doctor to be interested in him, he ought to try to *be* interesting. When he shows nothing but a greediness for care, nothing but the coarser forms of anxiety,

it's only natural for the physician to feel an aversion. There is an etiquette to being sick.

I wouldn't demand a lot of my doctor's time; I just wish he would *brood* on my situation for perhaps five minutes, that he would give me his whole mind just once. I would like to think of him as going through my character, as he goes through my flesh, to get at my illness, for each man is ill in his own way. Proust complained that his physician did not allow for his having read Shakespeare. I have a wistful desire for my relation to my doctor to be beautiful—but I don't know how this can be brought about. Though I see us framed in an epiphany, I can't make out the content.

Just as he orders blood tests and bone scans of my body, I'd like my doctor to scan me, to grope for my spirit as well as my prostate. While he inevitably feels superior to me because he is the doctor and I am the patient, I'd like him to know that I feel superior to him too, that he is my patient also and I have my diagnosis of him. There should be a place where our respective superiorities could meet and frolic together.

Since technology deprives me of the intimacy of my illness, makes it not mine but something that belongs to science, I wish my doctor could somehow restore it to me

TALK TO ME continued on page 50



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INSIGHT

By Mary E. Moore, Ph.D., M.D.

**A VISIT TO THE
OPHTHALMOLO-
GIST OPENED THIS
PHYSICIAN'S EYES
TO DOCTOR-PATIENT
COMMUNICATION.**

The problems with my eyes had become alarming. Two and a half years ago I was told I had a posterior vitreous detachment in my left eye that had left me with an eye full of floating debris. Over the past two weeks, I had developed a similar problem in my right eye, its onset heralded by flashes of light when I turned my head. I found it almost impossible to focus a microscope on joint-fluid samples, a major inconvenience for a rheumatologist. After a MEDLINE search taught me that retinal damage was possible, I decided to consult a specialist at a large eye hospital in the city. My husband agreed to accompany me.

Outside, the massive, modern hospital was impressive. Inside, it was a different story. The entrance was a short, bare hallway ending at a receptionist desk. A remarkably unreceptive receptionist answered my request for "Dr. Dareeno" with bored, mechanical responses.

"Second floor. Elevators on the right. Retina services." By this time, my predictable anxiety was affecting my bladder capacity, and I was glad to see, on exiting the elevator, a sign for restrooms.

The ladies' room was depressingly filthy, especially considering that the day was only half over. Used paper littered the floor. I had the wild fantasy of sightless women going to the bathroom and washing their hands, all the while flinging dirty toilet paper and towels toward unseen receptacles.

My destination was a cavernous, dimly lit hall, painted a sickly tan, running along one side of the building. It was lined with chairs and potted palms and was punctuated along its inner wall by counters announcing different services. One of the first, and least promising, was "Low Vision." We thankfully left that behind. "Retina Services" was at the far end. I gave my name at that counter and was relieved to learn that I was expected. A sign posted nearby read, "If your vision has not been taken by a technician within 15 minutes after you arrive, please check with the receptionist."

Good Lord, I thought. After they make off with your vision do you go back to the "Low Vision" station? Or was there one I missed called "No Vision"?

My morbid thoughts were interrupted by the clerk behind the counter, who was looking at me speculatively.

"Are you 65?" she asked.

I, who was only 64 and two months, replied emphatically, "No."

"Then sit over there and fill out these forms," she

instructed. At last, something on which I could concentrate and that would display my superior grasp of medical paperwork. Under "Occupation" I proudly filled in "physician" and wrote, in the space indicated, a brief (21-word) medical history of my eye problem, using "O.D." and "O.S." to display my knowledge of ophthalmologic terminology.

I had long since finished the forms when the technician assigned to "take" my vision called my name for a turn at the eye chart. Why hadn't I cleaned my contact lenses? Now they would think my vision was worse than it really was. I blinked to try to separate the junk on the lenses from the junk in my eyes. Why did the technician's manner give me the feeling that I was flunking an IQ test? When I had humiliated myself sufficiently, she introduced drops into my eyes, careful to give no clue about the effect they would have. Gradually, a nauseating fog involved my visual world.

"Mary Moore," a voice called out through the fog. "Come in and sit down, Mary," requested a young woman, whom I had never met before, in unexpectedly familiar terms. At least she was smiling, the only smile I had seen anywhere in the hospital. A middle-aged man in a white coat approached. Thank goodness, a colleague.

"I'm Dr. Dareeno," the man announced briskly, avoiding my pleading-for-empathy gaze. "Tell me about your eye problems." I could sense I had to talk fast. I began the first of my 21 words. "Yes, yes," he

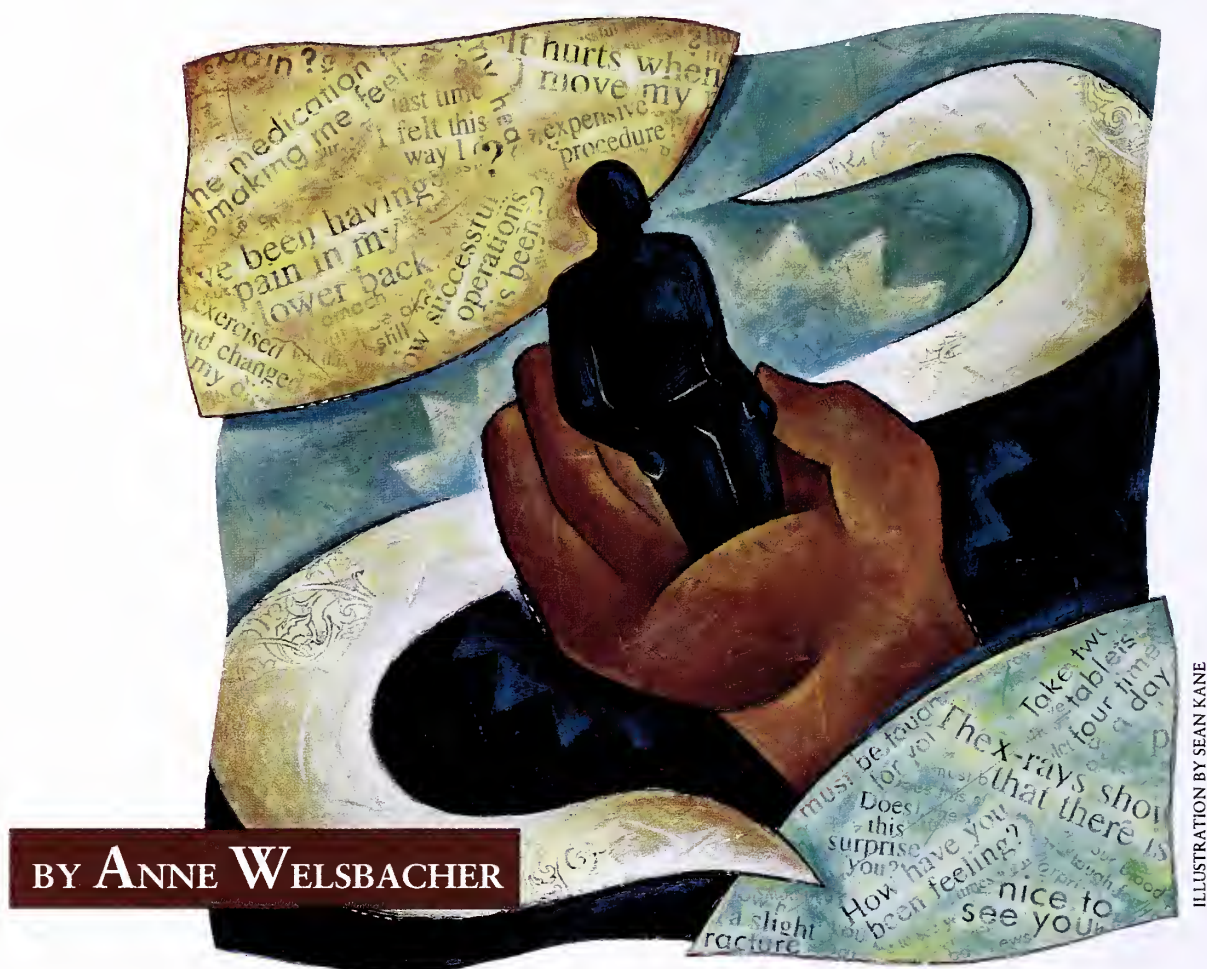
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ILLUSTRATION BY DAVID YAFFE

*The give-and-take of
doctor-patient
communication*

CAN YOU RELATE?



BY ANNE WELSBACHER

ILLUSTRATION BY SEAN KANE

*S*ure, you can detect a heart murmur or read a CT scan with the best of them, but do you know how to talk—and listen—to the people whose charts you compile?

Greg Lucas-Silvas, M.D., remembers approaching the head of a Twin Cities medical institution in the early 1980s with the idea of offering communication workshops for physicians. The response he got was, “Greg, how can you even consider spending two and a half days teaching doctors how to *talk*?”

Fifteen years later, health plans, medical schools, and clinics are spending time and money teaching physician-patient communication. And doctors are listening. They watch each other on videotape, attend or even perform in concerts and plays, and engage in soul-searching exercises about their relationships with others.

This increased attention to communication skills is driven by reasons as old as medicine itself and as new as managed care. Bottom-line concerns certainly

“Most people come in with complaints and concerns stemming from stress, from life, from things going on for them that we don’t have a pill for—and that we *shouldn’t* have a pill for. They need reassurance, a relationship. They need to talk things out.”

—JOHN BUTLER, M.D.

play a part: most malpractice suits are brought because of poor communication between doctors and their patients (see related article, page 28).

“You don’t sue someone you like or respect,” says James Boulger, Ph.D., who teaches at the University of Minnesota–Duluth School of Medicine. “So the more personal the relationship, the less likely you’ll see your patient in court.”

Good communication skills also contribute to better health care. Physicians can educate patients about everything from why antibiotics won’t cure a virus to why generic medications may be just as effective as branded products. And when physicians communicate clearly, their patients are more likely to take the right medications in the right dosages, says John Erwin, M.D., a Mayo Clinic resident who chairs the MMA’s Resident Physician Section.

Listening to patients is as important as talking. “Just letting the patient answer questions more fully can give answers not gotten anywhere else,” says Erwin.

Another compelling argument for good interpersonal skills is what they can do for the physician. Rob Wagner, M.D., who teaches a seminar through HealthPartners, says good communication is a “survival tool” for the modern physician, who must juggle criticism from all sides. “In this era when everyone has to cater to the customer, and doctors are now employees without the autonomy of the past, we’re pushed, we have no power, everybody tells us how crappy we are—it’s very frustrating.” He says physicians who really communicate with their patients often feel less stressed by these forces and more fulfilled by their work.

OBSTACLES TO COMMUNICATION

Physicians have trouble communicating with their patients for as many reasons as there are physicians.

Naturally, they’re subject to the same personality quirks that characterize all people. “Humans are quite complex; communicating is not a simple task,” says Lucas-Silvas, who teaches a communications seminar through HealthSystem Minnesota.

And if relational skills aren’t inherently easy, nor are they widely taught in medical school. In a national survey of primary care doctors, 61 percent said their medical education did not adequately train them to communicate effectively with patients.

Some doctors resent being asked to do what they see as public relations, not real medicine, says Wagner. He notes that the skills that earn respect from colleagues are often very different from those that patients admire.

Physicians also resist learning better relational skills because of fear, Lucas-Silvas says. “When you really start listening to your patient, you hear heart-breaking stories, and it tests one’s own depth. This touchy-feely stuff can be frightening to physicians, but this is what people want. People want healers—they don’t want just technicians.”

The search for healers is part of why so many people are turning to alternative medicine, believes John Butler, M.D., who also leads HealthPartners’ communications seminars. “They’re not getting what they need from traditional medicine,” he says. “We have a bag of pills; we have a lot of surgical procedures. But most people come in with complaints and concerns stemming from stress, from life, from things going on for them that we don’t have a pill for—and that we *shouldn’t* have a pill for. They need reassurance,

a relationship. They need to talk things out." He concedes that building this kind of rapport isn't easy for a physician under pressure. "But you have to constantly remind yourself that it's important."

Even physicians eager to enrich their relationships with patients face obstacles. People with different cultural backgrounds, for example, communicate differently. Mayo resident John Erwin recalls treating patients from a Middle Eastern country where custom forbids telling patients they have a terminal disease. "That's very frustrating to U.S. physicians, who are taught to be honest with their patients."

There are "cultural" differences among physicians, too. "I'm a family practitioner—a soft touch," says Wagner. His peers, he claims, are more likely to come from working-class backgrounds, than, for example, internists, who might be more cerebral, more formal—and, sometimes, harder to talk to.

Different physicians have different hot buttons. A surgeon, working in a high-stakes arena, may feel threatened if a patient asks for information about his or her track record. "The surgeon interprets such a question as saying, 'You're questioning my competence,' whereas the patient is simply scared of the upcoming operation," Butler says.

Patient expectations also present obstacles. Since the middle of this century, particularly in the United States, technology has become an article of faith. Patients expect their doctors to be able to fix every-

thing. These expectations are fueled by media coverage of new or experimental procedures—without the fine print about what can and can't be done on an individual, case-by-case basis.

Further, doctors' expectations often mirror those of their patients. "We *want* to fix anything that comes along," says Erwin. "Now we are learning that we can't."



"There's a perception that it takes a lot of time to build a relationship with patients. In fact, good communication does not have to take a lot of time. Developing skills in communication means learning how to deal with time more efficiently."

—ROB WAGNER, M.D.

house—look, here's how to do a focused 15-minute history."

He continues, "Initially, my students might well take an hour and a half to do a history, and you just can't *do* that."

But some physicians find that time is not necessarily a problem. "There's a perception that it takes a lot of time to build a relationship with patients," says Wagner. "But in fact, good communication does not

TIME WAITS FOR NO ONE

Time, many physicians emphasize, is the single biggest barrier to developing good relationships with patients. Particularly for doctors in managed care settings who see dozens of patients a day, it is simply not possible to spend more than 15 or 20 minutes with a patient.

Medical students learn how to do highly comprehensive patient histories. But once they get into the real world, says UMD professor James Boulger, they discover the reality of practice. "Their mentors will say to them, 'Oh, come on, this is practice, you can't ask them if they have lead-based paint on the walls of the second bedroom in the fourth floor of their

have to take a lot of time. Developing skills in communication means learning how to deal with time more efficiently.”

COMMUNICATION 101

Many strategies taught in seminars and medical schools are based on common sense. Avoid jargon when speaking to a patient (this, say teachers, is one of the most common mistakes). Pay attention to body language: nod to indicate you're listening (be sure you really are listening), make eye contact, don't bury your face in a medical chart while the patient is

talking. Make conversation with the patient before asking her to undress for an exam.

But these guidelines are only a beginning. Seminars offered through institutions like HealthPartners, HealthSystem Minnesota, Fairview Hospital, and Midwest Medical Insurance Company use videotaping and role-playing exercises—sometimes with actors—to help physicians see themselves in new ways.

Under the unrelenting eye of the camera, doctors see all their blemishes. “Physicians can know all this stuff—how we're supposed to shut up and listen to the patient, how we should keep our heads out of the

CALLING ALL DOCTORS

It's Saturday afternoon, and the heartburn-like pain in your chest that started last night hasn't gone away. You're a doctor yourself, but you would feel better if you talked to your own physician, one of the best in the city. You call the clinic.

“Hello, you've reached OptiMed Health System,” a female voice intones. “If you are calling from a touch-tone phone, please press 1 now. Otherwise, please hang up and get a new phone. If you're a member of OptiMed Plus, please press 1 now. If you're a member of the Standard Plan, press 2. For OptiMed Seniors, press 3. For OptiMedKids, press 4.”

Your head is beginning to ache. Soon the perky voice offers another menu of options.

“If you're experiencing shortness of breath, heart palpitations, or chest pain, press 1 now. If your symptoms involve the ear, nose, or throat, press 2. If you have a temperature in excess of 102, press 3. For temporary blindness or vision problems, press 4. If you are hearing voices directing you to kill a political figure, press 5. ...”

When physicians become patients themselves, they sometimes discover that their patients are right—doctors can be hard to reach. Richard Lussky, M.D., a neonatologist at Hennepin County Medical Center, recalls that when his infant daughter became ill, he had a difficult time getting through to her pediatrician.

“It made me wonder how accessible I am to my patients,” he says. “No one wants to be put on hold for 20 minutes, or to have to call three different

numbers before you can talk to a real person.”

Realistically, it may not be possible for physicians to answer calls directly. But health care professionals can take steps to make sure their patients can reach them. These questions will help you figure out if you're really accessible and how to become more so.

- Do you or your staff receive many complaints about phone service or messages?
- Do patients get frequent busy signals at your clinic? (US West will do a study of how busy your phone line is for a fee.)
- Do patients get put on “terminal hold”?
- Do important patient messages get lost in the system and never make it to the doctor (or make it there too late)?
- Do you hear that patients can “never talk to a doctor” at your clinic?
- Do you have enough phone lines to handle the volume of calls?
- Do you have enough staff to handle phone calls?
- Could some phone calls to your office be handled by other means, such as fax messages or answering machines for pharmacy renewals?
- Could the number of phone inquiries be decreased by providing information about hours, billing, routine testing, etc., through newsletters or clinic postings?
- If you are considering a voice messaging system like that of our imaginary OptiMed, what is the average age of your patients? If your patients are elderly, reconsider. If not, keep it simple.

charts—but until you see it happening in a workshop, you just don't know you're doing it," says Butler. "When physicians see themselves on video, they see all their problems right away—I don't have to tell them a thing."

AILING RELATIONS: THE TOP 10 COMPLAINTS

Things that drive doctors crazy

1. Mistrust, as when patients question the role of insurance companies.
2. Patients with lists of symptoms or questions.
3. Pressure to diagnose.
4. Patients who seem to cultivate illness to get attention.
5. Patients who don't take care of themselves but expect doctors to fix them.
6. Patients who think doctors are money-hungry.
7. Media-generated hype about the disease of the month.
8. Influence from organizations such as insurance companies.
9. Lack of freedom and other job pressures.
10. Regulations such as informed consent rules that force doctors to think in legal terms and detract from their serving as patient advocate.

Patients' gripes about doctors

1. Patronizing attitudes.
2. Insensitivity, especially about hard-to-diagnose ailments.
3. Not listening.
4. Lack of time spent with patient.
5. Unclear explanations.
6. Arrogance.
7. Closed-mindedness to nontraditional approaches.
8. Lack of caring about the whole person.
9. Money orientation.
10. Insensitive diagnoses or discomfort relaying bad news.

—Source: "Healing Wounded Doctor-Patient Relationships" by Linda Hanner and John J. Witek, *Kashan Publishing*, \$14.95. The book is available through the following Web site:
<http://members.aol.com/symptoms5/index.html>

Typically, the improvement at this stage is dramatic, and physicians quickly move on to higher level work. They learn to express empathy by saying things like, "This must be tough for you."

"Most doctors loathe role-playing," Wagner says. "But it forces them to think about this stuff, and sometimes it's the most powerful part of a workshop, especially when they're in the role of the patient."

Butler agrees. "Working with actors is fantastic. You can call a time-out, you can back up and talk about how people are feeling, what you could have done differently."

Lucas-Silvas shows clips from the movie "The Doctor," in which actor William Hurt plays a physician with a potentially lethal illness. The film illustrates how insensitive physicians can be when telling their patients news they don't want to hear.

Studies confirm that doctors have trouble breaking bad news, especially when the patient is a child. A survey in a recent issue of *The Journal of Developmental and Behavioral Pediatrics* found that many parents of chronically ill or disabled children encountered insensitive remarks and other hurtful behavior from doctors and other health care professionals.

"We get very little training in dealing with these issues," Robert W. Blum, M.D., a pediatrician at the University of Minnesota Medical School and one of the survey authors, told *The New York Times*. "As is true of people in general, we often don't know what to say."

Although guidelines for conveying bad news have been published in medical journals, research indicates that most doctors do not follow them. The suggestions include imparting the information clearly, privately, without interruptions from colleagues or beepers. Patients complain about doctors who keep a "stiff upper lip" or focus only on the medical facts.

"The cognitive mind shuts down when bad news is delivered," Lucas-Silvas says. "When I see that my patient has gone away, my response is to jump in with more information—and usually jargon at that. This just blows away the patient." At that point, a more effective tactic is to slow down. "Ask the patient, 'Does this surprise you?' or say something like, 'This is big news, isn't it?' Wait until you see the light go back on in their eyes to start talking again."

THE ART OF MEDICINE

The Mayo Center for Humanities in Medicine brings a rich array of theater, music, painting, sculpture, and

literature into the lives of the people who work and stay at Mayo. Plays by Eugene O'Neill, Lee Blessing, and Tina Howe are performed by heavyweights Jason Robards, Kathy Bates, Linda Lavin, and other actors. Extensive art exhibitions and a wide range of orchestral, ensemble, and chamber concerts have featured the talents of professional artists and gifted Mayo physicians.

In conjunction with the exhibitions and shows are forums intended to spur dialogue about issues from alcoholism to aging to malpractice.

Jerrett Richardson III, M.D., who oversees the program, recalls, "When Jason Robards came out after performing *Long Day's Journey Into Night* and talked with the audience about alcoholism, [he] reached a broad group of people who'd come to see the play but who would *not* have come to a forum about alcoholism and denial—who wouldn't even care to talk about alcoholism and denial."

At the program's core is the belief that art can be a catalyst for physicians to see their relationships with others as a creative process. "Art reaches people at a gut level," says Carolyn Beck, Ph.D., a cultural anthropologist who coordinates the program.

Jon Halberg, M.D., used literature as a springboard for discussion in a four-week course he and other practicing physicians taught for the first time in fall 1996 at the University of Minnesota Medical School. For the first time, communication was incorporated into the beginning semester of medical training.

"For the U, this was quite a change," Halberg says. "Historically, medical students don't have interaction with physicians right away—the first two years are on basic science. But I argue that literature is no less important than the Krebs cycle for a student learning how to be a good physician."

Because art is about expression, it's a potent tool for learning to communicate better. "Artists allow us to see the world in ways we might not have thought to look," Halberg says.

Students read works by, among others, psychiatrist Robert Coles, who calls on physicians to "grapple with difficult issues—including, by extension, better understanding of the different lifestyles of living people."

Halberg and others were brought into the program by Steven Ytterberg, M.D., who teaches the two-year introductory sequence at the Medical School and became the course's director in 1989. "First-year

students have got a great sense of humanity—they're not cynical yet," Ytterberg says. "So this is a good time to teach them. Some people think it's too soon because they haven't learned enough yet, but I think it's a wonderful time—*because* they haven't learned enough yet."

IS THE MESSAGE GETTING THROUGH?

The various physician-patient communication seminars in Minnesota have been well attended; 95 percent of HealthPartners' family practice physicians and internists, for example, have taken those workshops. And responses to training—from practicing physicians to first-year med students—are overwhelmingly positive. But in Minnesota and at national workshops like those offered by Bayer Institute, the Kaiser Institute, and the American Academy for the Physician and Patient, attendance often is artificially enhanced; frequently, the workshops are mandatory or simply very easy to attend.

Classes and workshops can help physicians identify problematic behaviors, but one seminar won't change them. A major challenge to putting newfound principles into action is finding the time to continue training.

Some frustrations will probably never disappear—time constraints, bottom-line pressures, human foibles. Still, "people" skills have progressed in the past decade or so. "The way we trained physicians for a long time was two years of science, two years of clinical work, and you're done," says Boulger. "It had very little to do with patient care."

Lucas-Silvas takes a long view of the issue. "It's only been in the past 50 years or so that people could go to a physician with a better than 50-50 chance of being helped," he says. "Before then, they got arsenic or were bled or had their wounds cauterized with boiling oil. ... Now we have all this tremendous technology. But in every society there were always healers who held central roles and were held in high esteem. What was it about Hippocrates, about Sioux medicine men? It had something to do with their relationships with their patients."

"What if we could combine our technology with the relationships they were able to develop? We would have the most powerful and humane healing profession the world has ever seen. It's an amazing potential. And I think it's within our grasp." **MM**

Minneapolis writer Anne Welsbacher writes on health, science and nature, the arts, history, and other topics.

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

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References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

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Use of Hazardous Substances in the Care of Rural Cancer Patients

Current Practice Standards

David E. Gangeness, Pharm.D., Byron J. Crouse, M.D., and Thomas E. Elliott, M.D.

ABSTRACT

A growing number of rural cancer patients are receiving chemotherapy in hometown clinics and hospitals. Local access to cancer care offers many advantages to patients and providers, but is it safe to give intravenous chemotherapy? What precautions should be taken? Most physicians are well aware of the regulations pertaining to the use of universal precautions to prevent the spread of infectious diseases. A similar approach should be used for hazardous substances. As health care leaders and employers, physicians need to know the risk of expasing employees and themselves to potentially hazardous substances like chemotherapeutic agents. This paper offers current information for physicians to consider when providing cancer care in local health care facilities.

Most rural physicians who care for cancer patients are family practitioners and general surgeons. Cancer specialists, such as medical oncologists, hematologists, radiation therapy oncologists, oncology surgeons, and oncology clinical nurse specialists, are generally clustered in metropolitan areas.^{1,2} Consequently, rural cancer patients usually must travel to obtain early oncology specialty intervention, but ongoing travel to specialty centers can be burdensome and expensive. A recent trend is for rural cancer patients to receive more cancer care in their home communities. A growing number of rural health care facilities are offering state-of-the-art follow-up cancer care, including chemotherapy.³

Cancer tends to be a disease of older citizens. Depending on the definition of rural, about 19% of Minnesota's rural population is over age 65, whereas in the Minneapolis/St. Paul metropolitan area about 12% of residents are over age 65.⁴ As rural populations get older, the prevalence of cancer as a life-threatening illness will continue to increase, and more rural health care facilities may decide to offer chemotherapy.

The preparation, administration, and disposal of chemotherapeutic agents may expose nurses, physicians, pharmacists, and other health care workers to potentially significant levels of chemicals.⁵ Primary care physicians need to realize that their responsibility for supervising and coordinating the health care of patients also includes overseeing the safety of employees and other health care professionals involved in caring for pa-

tients treated with hazardous materials. Therefore, they must be aware of the standards of practice. The three prime considerations are 1) regulations from the Occupational Safety and Health Administration (OSHA) section of the U.S. Department of Labor, as well as Employee Right to Know Rules;⁶⁻⁸ 2) proper equipment, such as a laminar flow hood or biological safety cabinet; and 3) employee education on handling chemotherapy.^{9,10} In many respects, the approach to safely handling hazardous substances mirrors universal precautions taken to prevent the spread of infectious diseases.^{11,12}

LAWS AND REGULATIONS

OSHA standards recognize the hazards of many chemotherapeutic agents and treat these agents the same as hazardous chemicals in other industries. Employers are responsible for providing employee education and an appropriate environment for handling, storing, administering, and disposing of these agents. Baseline and periodic medical evaluations of employees is required for some agents and remains controversial for others.

OSHA standards apply in all settings where employees are exposed to hazardous drugs, such as hospitals, physician offices, and home care agencies. In Minnesota, most regulations fall under the jurisdiction of the state OSHA office (the federal office administers OSHA only for federal institutions, such as VA hospitals and maritime work sites). Laws and regulations related to training employees and OSHA standards may be obtained from the Minnesota OSHA office, 612/296-2116 or 800/342-5354.

THE LAKE SUPERIOR RURAL CANCER CARE PROJECT

The Lake Superior Rural Cancer Care Project (LSRCCP), sponsored by the National Cancer Institute, creates rural multidisciplinary health care teams that include physicians, pharmacists, and nurses to explore methods to improve cancer diagnosis and management in rural areas throughout our region (see the figure at right). In this region, 70% of the population is rural-residing (approximately 25% of the United States is rural by most standard definitions¹).

Many health care providers and their facilities are referring cancer patients to urban centers for cancer care, which exacerbates the health care problems of rural areas and increases the barriers to care for rural cancer patients.

Cancer care offerings, including the administration of antineoplastic agents, have increased in LSRCCP communities.² A survey of chemotherapy agents currently offered in LSRCCP communities revealed an extensive list that includes many of the typical chemotherapeutic agents used in large urban centers (see the table below).

ACKNOWLEDGMENT

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grant no. RO1 CA56334; Principal Investigator, Thomas E. Elliott, M.D.

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Table

Hazardous drugs dispensed in rural communities

bleomycin	fludarabine	mitomycin (Mutamycin®)
carboplatin (Paraplatin®)	fluorouracil (5FU)	mitoxantrone (Novantrone®)
carmustine (BCNU)	goserelin implant (Zoladex®)	paclitaxel (Taxol®)
chlorambucil (Leukeran®)	hydroxyurea (Hydrea®)	tomoxifen (Nolvadex®)
cisplatin (Platinol®)	leucovorin	thioguanine
cyclophosphamide (Cytosan®)	leuprolide (Lupron®)	thiotepa
cytarabine (Cytosor-U®, ara-C)	mechlorethamine (Mustargen®)	topotecan
doxorubicin (Adriamycin®)	mercaptopurine	vinblastine (Velban®)
etoposide (VePesid®, VP-16)	methotrexate	vinorelbine (Navelbine®)

Source: LSRCCP pharmacist survey, 1996

Further information about OSHA may be obtained from its Web site: www.osha.gov.

The Employee Right to Know Act of 1983 (ERTK) requires employers to evaluate their workplace for the existence of hazardous substances, harmful physical agents, and infectious agents and to provide ongoing training and information to employees who are routinely exposed to these substances and agents. When agents and work practices change, employees must be educated. The employer must perform scheduled assessments of hazards and keep a list of hazardous substances that employees handle. Employers are responsible for documenting the appropriate level of training before assigning job duties. Training must be done upon hire and annually and must include the appropriate labeling of substances; the location, proper use, and disposal of personal protective equipment; and the proper storage and disposal of hazardous substances.

EQUIPMENT

Proper selection of equipment is an important component of employee protection. One essential technical component is the laminar flow hood or biological safety cabinet (BSC). When first introduced, laminar flow hoods were used to help keep pharmaceuticals sterile and to protect the patient. Now their function is to provide a safe environment for employees to handle hazardous substances. The hoods have allowed employees to handle chemotherapy safely and make it available for the local treatment of cancer patients.

The most practical and effective equipment for minimizing exposure during preparation of chemotherapy agents is the Class II BSC. There are four main types, all of which have downward airflow and high-efficiency particulate air (HEPA) filters. The difference is the amount of air recirculated within the cabinet, where the air is vented, and whether the ducts are under positive or negative pressure.

- *Type A* cabinets recirculate approximately 70% of cabinet air through HEPA filters back into the

cabinet; the rest is discharged through a HEPA filter into the preparation room. Contaminated ducts are under positive pressure.

- *Type B1* cabinets have higher-velocity air inflow, recirculate 30% of the cabinet air, and exhaust the rest to the outside through HEPA filters. They have negative-pressure contaminated ducts and plenums.

- *Type B2* systems are similar to Type B1 except that no air is recirculated.

- *Type B3* cabinets are similar to Type A in that they recirculate approximately 70% of cabinet air. However, the other 30% is vented to the outside and the ducts are under negative pressure.

The Class II, Type B BSCs are recommended since they vent to the outside, but the added expense of venting outside may be prohibitive or impractical at some sites. Some outpatient settings may not be able to justify the cost of a hood at all and may outsource the preparation of chemotherapy to nearby facilities that offer parenteral compounding. Of course, all the employee safety concerns related to administering the drug would still apply.

THE EDUCATION AND PROTECTION OF EMPLOYEES

Proper education of employees in handling, preparing, administering, and disposing of hazardous drugs is vital. Training and education should accompany implementation of the hood. OSHA has published standards for the safe management of chemotherapy.¹³ These standards provide a framework for controlling occupational exposure to hazardous drugs.

To further prevent occupational injury and disease, physicians should institute safety programs that include medical surveillance of workers exposed to chemical hazards. A complete discussion about the risks involved with handling chemotherapy may be found in recent articles in the *American Journal of Health-System Pharmacy*.^{5,13,14}

It's important to remember that many chemotherapeutic agents are not only carcinogenic, but teratogenic. Pregnant women should not be

exposed to chemotherapeutic agents.

OTHER HAZARDOUS SUBSTANCES

There is no standardized reference for hazardous substances, nor is there complete consensus on which agents should be included. Therefore, it is essential to minimize exposure to all potentially hazardous substances, such as antineoplastic agents, antibiotic drugs, and strong acids or alkalis (like cleaning agents or some pharmaceuticals). All should be handled or prepared in the controlled environment of a BSC.¹³

Further information on the subject is provided in the "American Hospital Formulary Service, Drug Information 96 Technical Assistance Bulletin on Handling Cytotoxic and Hazardous Drugs," available from the American Society of Health-System Pharmacists.

In addition to chemotherapeutic agents, a number of pharmaceuticals in the health care setting may pose occupational risk to employees through acute and chronic workplace exposure. Four drug characteristics could be considered hazardous:

- genotoxicity;
- carcinogenicity;
- teratogenicity or fertility impairment; and
- serious organ or other toxic manifestation at low doses in experimental animals or treated patients.

CONCLUSION

Purchasing a hood and providing employee training may seem like a large expenditure at a time of shrinking budgets, but the availability of cancer chemotherapy in rural areas is becoming more prevalent. Exposure to hazardous substances has long-term implications. Like universal precautions, which are promoted to reduce the transmission of infectious diseases, special handling of hazardous substances makes sense. Physicians are just as responsible for the safety of their employees and coworkers as they are for their patients. MM

David Gangeness is a senior clinical scientist and Thomas Elliott is director, Division of Education and Re-

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search, St. Mary's/Duluth Clinic Health System in Duluth, Minnesota. Byron Crouse is associate professor and head of the Department of Family Medicine, University of Minnesota-Duluth School of Medicine.

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Preparing for a Change in Metered-Dose Inhalers

Physicians should be ready to answer patients' questions about the worldwide phaseout of chlorofluorocarbon-propelled inhalers.

National Asthma Education and Prevention Program CFC Phaseout Working Group*

Editor's Note: Just when we are becoming comfortable with the newest guidelines for management of asthma (Guidelines for Diagnosis and Management of Asthma from the National Asthma Education and Prevention Program from the National Heart Lung and Blood Institute), we find that recommendations will change again. While changing the vehicle for an inhaler doesn't sound like a big deal, it is. Read on to see why we will have to change and what will happen when we do. Knowing what's to come may help us stay a little ahead of the curve.

—Barbara P. Yawn, M.D., M.Sc.
Series Editor

Clinicians who care for patients with asthma or chronic obstructive pulmonary disease are facing a change in the inhalers they commonly prescribe. A worldwide transition is underway to replace chlorofluorocarbon (CFC)-propelled metered-dose inhalers (MDIs) with medication delivery devices that do not contain CFCs. This phaseout of CFC MDIs will continue for several years as more non-CFC options become available.

Because most inhalers used today operate by means of a CFC propellant, the transition to alternative devices has significant implications for patient education and care. Health care providers will assume a critical role in informing their patients about the CFC phaseout, allaying fears, and teaching correct use of new devices. Consequently, it is important for primary care physicians and other clinicians to familiarize themselves with the change taking place.

This article addresses a number of important questions that health care providers should be prepared to answer for their patients.

WHY ARE CFC MDIs BEING PHASED OUT?

Although CFCs in medicines are safe for patients to inhale, CFCs deplete the ozone in the earth's stratospheric ozone layer. The ozone layer shields the earth from harmful ultraviolet radiation from the sun, and

ozone depletion can lead to increased risk of skin cancer and cataracts as well as other health and environmental problems. To help restore the ozone layer, most countries have agreed to stop using CFCs. The agreement, known as the Montreal Protocol, was signed in 1987.

CFCs are used in many products besides MDIs, including air conditioners and refrigerators, although they are no longer made for these purposes. The Montreal Protocol made an exception for CFC MDIs, however, because of their importance in treating asthma and chronic obstructive pulmonary disease. CFCs for use in MDIs will continue to be manufactured until safe and effective replacements are available. But the goal is to eventually replace *all* CFC MDIs with alternatives that do not contain CFCs. Although it will likely take a few years for this to happen, the process has already begun.

WHAT STEPS HAVE BEEN TAKEN TO CONVERT FROM CFC TO NON-CFC INHALERS?

Although the conversion is challenging, many professional, public, and private groups worldwide are working to ensure that medicines are available to properly care for patients during the transition from CFC to non-CFC inhalers:

- Companies around the world are testing inhalers containing non-CFC propellants. These new propellants have been shown to be just as safe for patients as CFCs.
- Other non-CFC options that don't require propellants are being developed, including dry-powder inhalers, mini-nebulizers, and other devices.
- The U.S. Food and Drug Administration (FDA) and the U.S. Environmental Protection Agency (EPA) are working together to ensure that CFC MDIs remain available until safe and effective replacements are developed.

- The National Asthma Education and Prevention Program (NAEPP), in collaboration with the International Pharmaceutical Aerosol Consortium, is developing educational materials regarding the transition to

Resources

The following organizations can provide information about asthma, other respiratory diseases, the Montreal Protocol, and the change to non-CFC inhalers:

Allergy and Asthma Network/Mothers of Asthmatics, Inc., 800/878-4403
<http://www.podi.com/health/aanma>

American Academy of Allergy, Asthma, and Immunology, 800/822-ASMA
<http://www.aaaai.org>

American Association for Respiratory Care 972/243-2272
<http://www.aarc.org>

American Lung Association
 800/LUNG USA
<http://www.lungusa.org>

American Pharmaceutical Association 202/628-4410
<http://www.aphanet.org>

American Society of Health-System Pharmacists, 301/657-3000
<http://www.ashp.org>

American Thoracic Society 212/315-8700
<http://www.thoracic.org>

Asthma and Allergy Foundation of America 800/7-ASTHMA
<http://www.aafa.org>

National Association of School Nurses, Inc. 207/883-2117
<http://www.vrmedia.com/nurses>

National Asthma Education and Prevention Program, 301/251-1222
<http://www.nhlbi.nih.gov/nhlbi/lung/lung.htm>

U.S. Environmental Protection Agency 800/296-1996
<http://www.epa.gov/ozone>

U.S. Food and Drug Administration 301/827-4420
<http://www.fda.gov>

International Pharmaceutical Aerosol Consortium, 202/408-7189
 E-mail: krouse@gcd.com

American College of Chest Physicians 847/498-1400
<http://www.chestnet.org>

American College of Allergy, Asthma, and Immunology, 847/427-1200
<http://allergy.mcg.edu>

European Federation of Asthma and Allergy Associations
<http://www.efanet.org>

non-CFC inhalers. Several NAEPP member organizations are also involved in patient education efforts, including the Allergy and Asthma Network/Mothers of Asthmatics, Inc.; the American Academy of Allergy, Asthma, and Immunology; the American Lung Association; the Asthma and Allergy Foundation of America; and representatives from the FDA and the EPA.

- The FDA will review the safety and effectiveness of every new non-CFC inhaler before it is approved.

WHICH MDIs WILL BE AVAILABLE DURING THE TRANSITION?

CFC MDIs will remain available until an adequate number of safe and effective non-CFC inhalers are available. It is not known how long this will take, but all patients should have adequate choice of medicines during the transition.

HOW WILL THE NEW INHALERS DIFFER FROM CFC MDIs?

There may be some differences in how CFC and non-CFC MDIs work, look, taste, or feel. One non-CFC MDI for the medicine albuterol is available now. Although patients may notice some minor differences in the feel or taste of the new product, the FDA has found it as safe and effective as the albuterol CFC MDIs.

WHAT ROLE WILL HEALTH CARE PROVIDERS PLAY?

Health care providers will be vitally important as the phaseout of CFC MDIs progresses. During these early stages of the phaseout, clinicians should tell patients about the changes that are taking place while reassuring them that their care will not be compromised. As new inhaler devices become available, providers will need to instruct patients how to use them. **MM**

*National Asthma Education and Prevention Program CFC Phaseout Working Group: Albert L. Sheffer, M.D. (chair), Harvard Medical School, Boston, MA; Robert A. Barbee, M.D., F.C.C.P., University of Arizona, Tucson, AZ; Noreen M. Clark, Ph.D., University of Michigan School of Public Health, Ann Arbor, MI; Fran DuMelle, American Lung Association, Washington, DC; Vivian Haines, R.N., M.A., S.N.P., Rushland, PA; John K. Jenkins, M.D., U.S. Food and Drug Administration, Rockville, MD; Thomas J. Kallstrom, R.R.T., Rainbow Babies and Children's Hospital, Cleveland, OH; Leslie Hendeles, Pharm.D., University of Florida Health Science Center, Gainesville, FL; Chris O'Donnell, U.S. Environmental Protection Agency, Washington, DC; Gary Rachelefsky, M.D., UCLA School of Medicine, Los Angeles, CA; Nancy J. Sander, Allergy and Asthma Network/Mothers of Asthmatics, Inc., Fairfax, VA; Barbara M. Santamaria, R.N., M.P.H., C.F.N.P., Veterans' Administration Medical Center, Baltimore, MD; Dennis M. Williams, Pharm.D., University of North Carolina School of Pharmacy, Chapel Hill, NC; Mary E. Worstall, M.P.H., Asthma and Allergy Foundation of America, Washington, DC. National Heart Lung and Blood Institute staff: Ted Buxton, M.P.H.; Robinson Fulwood, M.S.P.H.; Michele Hindi-Alexander, Ph.D.; Virginia Taggart, M.P.H., R.O.W. Sciences, Inc. Support staff: Lisa Marcellino and Eileen Zeller, M.P.H.

Malpractice Prevention: Good Doctor-Patient Communication

*Good rapport with your patients
can reduce your risk of malpractice lawsuits.*

Paul S. Sanders, M.D., and Debra L. McBride, R.N., J.D.

While being a poor communicator is not grounds for a malpractice suit, communication and rapport are essential to every physician-patient relationship. When those relationships suffer, you may be more vulnerable to malpractice claims. Plaintiffs' lawyers report that 70 percent of malpractice claims are brought because of physician-patient communication problems or as a result of the physician's attitude.

If patients are unhappy with your attitude, chances are you have heard about it in some way—from your HMO report cards, patients inexplicably leaving your practice, or direct complaints. You may even have had a malpractice claim resulting not from negligence, but from a patient angry about how you communicated.

It is tempting to dismiss patient complaints about attitude by saying, "I'm just too busy" or, "So I had a bad day." But patient perceptions about how caring you are can directly affect many areas, including:

- How well the patient adheres to your prescribed regimen. A patient who feels the doctor has not listened to his or her concerns is less likely to believe that the appropriate advice has been given. ("She didn't even ask me about the sneezing. How does she know I don't have allergies?")

- How comfortable the patient feels disclosing sensitive health information. Without a sense of trust, a patient may hesitate to reveal important health facts, such as sexual ori-

entation or risky behavior.

- How much patients understand about their health. Doctors who are perceived as caring and sensitive tend to use less medical jargon, and they elicit feedback about what their patients understand.

Good rapport with patients has widespread implications. This article, however, focuses on a specific area of communication: what doctors say to patients that affects their malpractice exposure. The physician-patient relationship is never more severely tested than when a patient suffers an unexpected adverse health outcome.

FROM PATIENTS TO PLAINTIFFS

Medical malpractice law firms report as many as 75 calls per week from unhappy patients seeking to sue their physicians. Of these calls, the well-known firms may accept three or four potentially meritorious cases per month.

The sheer number of angry patients is alarming. What are physicians doing that sends patients in droves to attorneys? Consider these actual physician comments as reported by plaintiffs in their depositions:

"If you're so concerned about your child's fevers, I suggest you buy a thermometer and learn how to use it." (Family physician sued for failure to diagnose meningitis in a 3-year-old child.)

"I can't be everywhere at once. The guy in the car accident was a lot worse off than your father at the

time." (Emergency physician sued for failing to properly treat MI resulting in the patient's death.)

"We don't have time today for you to give me your life's story. Can you sum up your concern in a nutshell?" (Ob-gyn sued for failing to diagnose breast cancer in a 29-year-old woman.)

Whether or not the quotes are accurate, these doctors come across as uncaring and unsympathetic. The patients' perceptions of their physicians' attitudes, coupled with adverse outcomes, may well have pushed these patients to become plaintiffs.

Research has shown that nearly three-fourths of plaintiffs in medical malpractice claims identified relationship problems as the impetus for their lawsuits. Busy physicians say they have less time to spend with each patient as the administrative demands of practicing medicine increase. Frustrated patients report being hurried through visits by doctors who don't listen and don't seem to care. The combination results in a tremendous risk of a malpractice claim if a patient injury occurs. Whether or not the physician rushed the patient or failed to listen may be immaterial if the patient perceived these problems and suffered a bad outcome.

MALPRACTICE CLAIMS RESULTING FROM COMMUNICATION PROBLEMS

"Improper performance of the diagnostic interview, evaluation, or con-

sultation" is the No. 1 allegation against physicians in nearly all specialties, according to national data collected by the Physician Insurers Association of America. In short, this means "failure to diagnose." The allegation typically arises when something is missed or not considered during the diagnostic interview.

An important symptom or some critical medical history that is overlooked can lead to a missed or delayed diagnosis. Plaintiffs often say their doctor "discounted" or "dismissed" concerns they raised that (in hindsight) could have led to the correct diagnosis.

In one malpractice case, for example, an internist received an early evening call from the wife of a diabetic patient. The wife reported that the patient was nauseated and "white as a sheet." The internist suspected a virus and reassured the wife that rest and clear liquids would resolve the illness. A short time later, the wife called again and left a message with the physician's answering service. When the internist called the wife back, she reportedly told him her husband was still nauseated, still very white, and having chest pains. (The internist later denied hearing the last statement.) He again attempted to reassure her, but she asked whether she should bring her husband to the emergency department. "If you bring him to the emergency department, you will just feel foolish when the flu is diagnosed," the internist reportedly said. An hour or so later, the patient arrested at home and was dead on arrival at the hospital.

The widow testified convincingly that the physician had been abrupt with her and had discouraged her from taking her husband to the hospital, dismissing as the flu the symptoms she described. The physician had not taken any notes on the two phone calls and denied that the wife had mentioned chest pain. But the answering service had logged the calls and showed that the second call of the evening listed chest pain as the patient complaint.

Did the physician's "abrupt" attitude cause the wife to hesitate and fail to describe a critical symptom?

The physician was certain that if the caller had mentioned chest pain, he would have immediately sent the patient to the emergency department. Unfortunately, it was impossible to determine what the physician heard during the call. The lack of documentation rendered the claim indefensible.

COMMUNICATING BAD OUTCOMES

Even excellent clinicians and diagnosticians are subject to human error, fatigue, or distraction. Things go wrong and sometimes patients sue. But physicians with good patient relationships are less likely to be sued, even when they make a mistake.

In one situation, medical staff missed signs of fetal distress during a delivery. The expectant father videotaped the delivery and panned the camera to the fetal monitor several times throughout the labor. The child was born severely compromised. The delivering physician was devastated and spent hours with the parents candidly discussing what had happened and sharing their sorrow.

To make things worse, the baby was given the wrong type of blood in intensive care and died within a day of her birth. The whole medical staff openly grieved with the parents of this infant, and the physicians and nursing staff attended her funeral. Three months after the baby's death, the couple hosted a thank-you party for the hospital staff. Even though the father had captured the entire tragedy on videotape, the family never considered suing. Two years later, they delivered a healthy infant under the same doctor's care.

A strong physician-patient relationship can often weather difficult outcomes, even complications resulting from errors. When an internist learned that a 41-year-old patient she was seeing for thyroid problems had suffered an MI, she immediately reviewed her chart to see if there were any clues. To her surprise, she discovered she had missed the patient's significantly elevated cholesterol.

After consulting her malpractice carrier's risk management depart-

ment, the physician visited the patient in the hospital and reviewed the chart with her. The physician explained that the patient's high cholesterol probably should have been treated and that early aggressive treatment might have reduced her risk of cardiac arrest. In the physician's concern about the patient's compromised thyroid functions, she had overlooked the cholesterol. The patient replied that she was just happy to have survived. In a letter to the clinic administration, she praised the care her family had received over the years and expressed her gratitude for her physician's candor.

These doctors, like many others, know how to connect with their patients and establish relationships based on caring, trust, and mutual respect. Most physicians practice this way. With increasing demands and busier practices, however, some physicians may forget or skip basic communication principles.

COMMUNICATION TECHNIQUES CAN MAKE A DIFFERENCE

According to the Bayer Institute for Health Care Communication in Connecticut, physicians who are sued most often have low patient satisfaction ratings. Despite outstanding technical skills, a doctor who is perceived as uncaring is more likely to be sued if a patient experiences an adverse result.

The good news is that communication techniques can be learned and do not necessarily add significant time to your patient interactions. Spending a few moments getting to know a new patient, recalling something personal about an established patient, asking open-ended questions, avoiding medical jargon, and expressing empathy are all behaviors patients rate highly.

The Bayer Institute developed workshops that allow physicians to evaluate their own communication techniques and compare themselves to other participants. Faculty members credentialed by the institute facilitate the workshops, presenting the research about communication and malpractice claims and exploring differences among participants' com-



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munication styles. Physicians report that by improving their relationships with patients, they see improvements in overall patient satisfaction. As an added benefit, the risk of a malpractice suit diminishes. The Midwest Medical Insurance Company, a physician-owned malpractice carrier based in Minnesota, offers the Bayer communication workshops free of charge to its insureds. (Many groups in Minnesota offer communications training; see cover story on page 14.)

The relationship between poor communication and malpractice claims has been established in numerous studies. Patient perceptions are critical. By evaluating your own communication style, you can increase your awareness of how patients see their interactions with you. The benefits of strong patient relationships include a reduced risk of malpractice lawsuits. **MM**

Paul Sanders is chief executive officer of the Minnesota Medical Association. Debra McBride is a manager of risk management at Midwest Medical Insurance Company in Minneapolis. Both are faculty members of The Bayer Institute for Health Care Communication. For information about attending a Bayer Institute communication workshop, contact Debra McBride at 612/922-5445.

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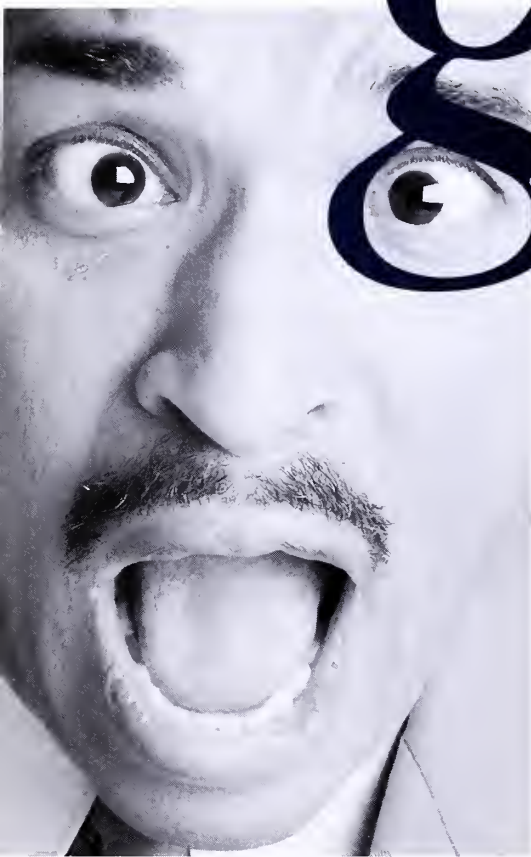
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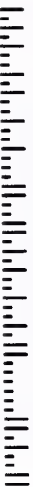
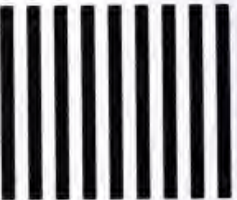
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HUNTLEY, HOTTINGER TO SPONSOR MMA BILLS

State Rep. Thomas Huntley, DFL-Duluth, and Sen. John Hottinger, DFL-Mankato, have agreed to sponsor three bills originating from the MMA House of Delegates. The three legislative initiatives are: a proposal to prohibit the use of DEA numbers for purposes other than drug enforcement (H.F. 2401, S.F. 2207); a proposal to ban the sale and distribution of tobacco to persons under age 21 (H.F. 2400, S.F. 2208); and a bill that would require all licensed child care homes to be smoke-free for 24 hours a day (H.F. 2399, S.F. 2209). Huntley, a member of the House Health and Human Services Committee, chairs the Health Care Access Subcommittee. Hottinger is chair of the Senate Health and Family Security Committee. The 1998 "short session" was beginning as the *Monitor* went to press; for more legislative coverage, see page 35.

• • •

UNIFORM CREDENTIALING TASK FORCE MEETS

The MMA Ad-Hoc Task Force on Uniform Credentialing held its first meeting on January 14. The task force, which includes 29 members from health plans, hospitals, independent practices, and rural and urban clinics, is working to develop recommendations for the MMA Board of Trustees on a uniform credentialing process for the state. The group, chaired by Benjamin Whitten, M.D., and staffed by Pat Hanson, MMA manager of quality and data, aims to complete a report for the BOT by midyear.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA to Offer Seminars on Contracting with Health Plans

In response to a resolution to the 1997 Minnesota Medical Association House of Delegates, the MMA will conduct a seminar this month on contracting with managed care organizations.

Attorney Carol O'Brien, director of the American Medical Association's new Division of Representation, will attend the seminar—to be held in the Twin Cities, St. Cloud, and Duluth—bringing a model managed care contract unveiled at the AMA Interim Meeting in December.

"Carol was instrumental in helping develop the AMA's Model Managed Care Medical Services Agreement," said Patricia Franklin, MMA director of legal affairs. "We'll be using that as our primary teaching resource."

Common Provisions Addressed

The model contract presents key provisions common to managed care agreements throughout the country. It addresses several issues of growing concern to physicians, such as late payment and termination without cause.

One of the document's most useful features is the explanatory information provided in the margins throughout each article. For example, in Article V, Company's Obligations, in the margin alongside "Provision of Financial Information," is the following parenthetical note: "Occasionally it is suspected that managed care companies slow payment of claims or reject an excessive number of claims as not being 'clean' in order to improve their financial

reporting. This provision (5.10) grants physicians and physician groups the right to review the company's quarterly balance sheet and income statement to eliminate such practices where they exist."

The workshops are being coordinated with the Minnesota Medical Group Management Association (MMGMA), and with the Hennepin, Ramsey, Stearns-Benton, and Lake Superior medical societies.

Resolution Led to Seminar

Discussion of how to implement Resolution 309—Physician Contract Education Program—led to planning the seminar, titled "The More You Know, the Better Your Contract." Resolution 309 calls for the MMA to work with the MMGMA to develop an educational program for physicians that addresses common elements found in physician contracts.

"We want physicians to be able to read a contract knowledgeably, ask appropriate questions, and get appropriate advice," Franklin said. The seminar is open to physicians, clinic managers, and clinic administrators. CME credit has been applied for.

The seminar will be conducted four times, with two sessions slated for the Twin Cities:

February 24: Northland Inn, Brooklyn Park, 7:30 a.m.

February 24: Northland Inn, Brooklyn Park, 1 p.m.

February 25: Radisson, St. Cloud, 7:30 a.m.

February 26: Holiday Inn, Duluth, 7:30 a.m.

Contracting continued on page 37



Viewpoint

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Kent S. Wilson, M.D.
President, Minnesota Medical Association

MMA Dives into 1998 Legislative Session

As the *Monitor* goes to press, legislators have just returned to the Capitol for the second half of the 1997-98 biennium. This session may seem anticlimactic after our success last year—we won repeal of the \$400 surcharge, reduction of the provider tax to 1.5 percent, and a tougher law to prevent young people from buying tobacco.

Fewer major health care bills are expected this year. The short session is traditionally devoted to the budget. Legislators say they intend to consider only the state's capital bonding bill and other "emergency" measures.

A narrow focus in 1998 may be good news for the MMA. In some ways, this will be a defensive session, a time to consolidate and preserve last year's victories. We could face renewed attempts to use the Health Care Access Fund for purposes other than health care for the uninsured. The governor has already proposed using the access fund for medical education, but after the MMA and others expressed strong objections, he backed off. The MMA will continue to oppose any new use of the access fund and argue in favor of identifying a broad-based funding source for the MinnesotaCare program.

The MMA has drafted three bills

to be introduced early in the session. Sen. John Hottinger, DFL-Mankato, and Rep. Thomas Huntley, DFL-Duluth, have agreed to sponsor all three MMA bills.

The MMA will propose a ban on the sale and distribution of tobacco to youths under age 21. It makes sense to raise the legal age for purchasing tobacco to 21—the same as the legal drinking age. Retailers with liquor licenses are experienced in preventing illegal sales to those who are underage. Hottinger and Huntley are the natural choices to help push this legislation. Huntley has consistently supported antitobacco legislation, and Hottinger received the Smoke-Free 2000 Coalition's Legislator of the Year award in November for helping to pass the Youth Access to Tobacco Act—a major MMA victory in 1997.

Another MMA proposal designed to protect the public health would require licensed daycare homes and centers to be smoke-free 24 hours a day. Research conducted at the University of Minnesota Cancer Center has shown the danger of secondhand smoke. In September the university released a study finding a tobacco carcinogen in nonsmokers exposed to cigarette smoke. Smoke clings to fabric and hangs in the air long after a cigarette is snuffed out.

In addition to the cancer risk, more respiratory illnesses and hospi-

talizations have been found among infants whose parents smoke, and maternal smoking has been linked to the incidence of bronchitis/pneumonia in the first year of life. Despite mounting evidence of the dangers of secondhand smoke, the MMA proposal will face stiff opposition. National welfare reform has put more parents to work, increasing the need for daycare.

The MMA has also drafted a bill to outlaw the use of Drug Enforcement Agency (DEA) numbers to track prescription histories of physicians for commercial use. The proposal would prohibit requirements that prescriptions bear a physician's DEA number unless the prescription is for a controlled substance in schedule II, III, IV, or V. Although the DEA has advised insurance companies that using DEA numbers for claims processing is inappropriate, some pharmacies refuse to accept phone prescriptions for antibiotics without the physician's DEA number.

Proposals responding to public concern about managed care may also be considered this session. The MMA serves on a task force—representing state agencies, health plans, insurers, consumer advocates, businesses, and health care providers—that has recommended that the state create a new Office of Health Care Consumer Advocacy and Information to help consumers deal with health plan denials or other problems. Controversy may arise over how to pay for this service.

The MMA is also concerned about finding a way for Minnesota to participate in KidCare—a federal program that gives states funding to develop new programs for uninsured children. Since the MinnesotaCare program already covers uninsured children up to 275 percent of the federal poverty level, Minnesota is looking for a way to gain federal matching funds without increasing eligibility so much that it affects the private insurance market.

The MMA will be an active player in these and all issues that affect the health of Minnesotans. • • • • •

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LEGISLATIVE NEWS

GOVERNOR PROPOSES \$10 MILLION FROM GENERAL FUND

Gov. Arne Carlson earmarked \$10 million in his 1999 supplemental budget for the Medical Education and Research Cost (MERC) Trust Fund. The MMA was pleased to learn that the allocation is recommended to come from the general fund, not the Health Care Access Fund.

The MMA and other provider organizations had expressed opposition to using provider tax revenue to fund medical education, arguing that as an investment benefiting all of society, it should be funded through broad-based taxes.

The MERC Trust Fund, established in 1996, first received state appropriation in 1997 and is currently funded by a combination of \$5 million from general revenue funds and \$3.5 million from the access fund. MERC dollars will be matched with federal funds this year to double the investment.

Medicare is reducing its financial support of medical teaching and research programs. According to figures from the Minnesota Department of Health, the Mayo Clinic and the University of Minnesota are expected to lose up to \$115 million in Medicare dollars for graduate medical education over the next five years. MERC funds allow for training to move outside of high-tech hospitals to community clinics and physicians' offices.

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CARLSON REQUESTS FUNDING FOR FETAL ALCOHOL SYNDROME

Gov. Arne Carlson, in his supplemental budget released January 14, requested \$5 million from the general fund for a fetal alcohol syndrome (FAS) awareness and prevention program. MMA leaders were gratified to see that the governor's proposal did not include a provision mandating CME on fetal

alcohol syndrome for physicians. While the MMA strongly supports efforts to heighten public awareness and educate physicians—particularly obstetricians, family physicians, and pediatricians—on FAS, it argued against requiring CME to meet that end. The MMA submitted written testimony in December opposing a recommendation by the Governor's Task Force on Fetal Alcohol Syndrome to mandate CME on FAS for all physicians.

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MMA PARTICIPATES IN AMA STATE LEGISLATION CONFERENCE

MMA leaders and staff members participated in a four-day AMA conference on state legislation in Orlando in January. The conference included presentations by legislators from several states, and from representatives of federal agencies such as the Health Care Financing Administration and the Department of Transportation, about numerous issues of interest to state medical societies.

Those issues included ERISA (Employee Retirement Income Security Act) and changing case law, provider-sponsored organizations and Medicare, highway safety, and health plan liability, said Dave Renner, MMA director of legislation and public policy.

Attending the conference on behalf of the MMA were Renner; John Van Etta, M.D., chair of the MMA Committee on Legislation; Linda Carroll-Shern, MMA associate director of state legislation; and Paul Sanders, M.D., MMA CEO.

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ERICKSON WINS IN 17A; CLARK WINS IN 23A

High school English teacher Sondra Erickson, R-Princeton, defeated DFLer Mardi Lacher in the January 6 special election for the House seat in District 17A. The election was

scheduled when Republican LeRoy Koppendrayser resigned to accept an appointment to the Public Utilities Commission. District 17A covers all of Mille Lacs County and parts of Kanabec and Morrison counties.

Attorney James T. Clark, R-Springfield, won a January 20 special election to fill the seat vacated by the death of Rep. Barbara Vickerman, R-Redwood Falls, who died in December of liver cancer. Clark defeated DFLer Bonnie McKnight.

Another special election was slated for January 27 to fill the vacancy in House District 51B created when Rep. Doug Swenson, R-Forest Lake, was appointed to a judgeship.

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MMA BACKS BILL TO REQUIRE PROVISION OF TRIGGER LOCKS IN PISTOL SALES

A bill that would require firearms dealers to provide pistol buyers with a trigger lock at the time of sale (H.F. 2410-Mullery) was introduced and referred to the state House Judiciary Committee. The MMA strongly supports this effort to enhance firearm safety in Minnesota.

In the 1996 legislative session, the MMA helped gain passage of a law requiring firearm owners to take "reasonable action" to prevent youths under age 18 from gaining access to stored firearms.

The MMA also developed a brochure/poster, "Unload It & Lock It: Your Physician's Firearm Safety Checklist." The publication includes crucial safety tips for gun owners and a checklist for secure storage and safe use of firearms. To obtain free copies, contact Beth Hoheisel at the MMA at 612/378-1875 or 800/342-5662.

The trigger lock bill, introduced by Rep. Joe Mullery, DFL-Minneapolis, must be passed by a policy committee in either body by February 13 to stay alive this session.

MMA Physicians Likely to Testify in Tobacco Trial

..... JURY SELECTION WAS underway—and tensions were mounting—in Minnesota's lawsuit against tobacco companies as the *Monitor* went to press. The state and Blue Cross and Blue Shield of Minnesota are seeking between \$1.5 billion and \$2 billion in actual damages for the treatment of smoking-related illnesses, plus punitive damage that could total several billion dollars more.

Minnesota physicians who may serve as expert witnesses for the state and Blue Cross include Richard D. Hurt, M.D., director of the Mayo Nicotine Dependence Center; Barbara J. Bowers, M.D., an oncologist at Minnesota Oncology-Hematology, P.A.; Scott F. Davies, M.D., director of pulmonary and critical care medicine at Hennepin County Medical Center; and Kevin J. Graham, M.D., director, preventive cardiology, at the Minneapolis Heart Institute.

For up-to-the-minute information on the trial, which is expected to last several months, check one of the following Web sites:

- Office of the Attorney General Web site: www.ag.state.mn/us/consumer (Click on "Hot News," then select "Tobacco.")
- Blue Cross Tobacco page: www.mnbluecrosstobacco.com
- Tobacco BBS (Bulletin Board System): www.tobacco.org

Coalition Calls for Tougher Laws to Combat Teen Drinking

The Minnesota Join Together Coalition to Reduce Underage Drinking—of which the MMA is a member—is one of several groups calling for passage of legislation aimed at eliminating alcohol sales to youths under 21.

Bills sponsored by Sen. Ember Reichgott Junge, DFL-New Hope, and Rep. Linda Wejcman, DFL-Minneapolis, would require periodic compliance checks of bars, liquor stores, and other liquor licensees. The coalition was among the sponsors of a January 15 news conference at the Capitol in support of the 1998 Legislation to Restrict Youth Access to Alcohol.

University of Minnesota student and undercover beer buyer Jeremiah Hawkins, 20, spoke about the ease with which he has purchased alcohol

at many stores. "Half the time the person won't even look up ... they just take the money and give me my change. It's as easy as that," Hawkins said. The bills also call for tighter controls on home delivery of alcoholic beverages, and would give municipalities authority to ban the sale of 50-milliliter bottles of alcohol.

Hawkins and St. Paul Police Lt. Mike Morehead both stressed that, outside of the legislative arena, adults need to take more responsibility with regard to teen drinking. In the wake of the fatal St. Paul auto accident on New Year's Eve, following a party at which police believe adults furnished alcohol to minors, Morehead admonished: "Parents, *please* do not buy alcohol for your teen children."

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Physicians Sponsor Antismoking Play

Component medical societies, specialty societies, and clinics are joining the MMA and the Smoke-Free 2000 Coalition in bringing an innovative antismoking program to elementary students in Greater Minnesota. The National Theatre for Children's educational play, "2 Smart to Smoke" entertains as it teaches that smoking is uncool.

The messages, developed in partnership with Cheryl L. Perry, Ph.D., of the University of Minnesota School of Public Health, are designed for children in kindergarten through sixth grade. Currently 5 percent of all seventh graders smoke cigarettes. Research shows that the decision to smoke is based on attitudes, knowledge, and beliefs about smoking that are developed years before a young person takes his or her first puff.

Allina Health System is sponsoring performances in the Twin Cities metropolitan area.

Joining the MMA and the Smoke-Free Coalition in sponsoring perfor-

mances in Greater Minnesota are: Brown County Medical Society, East Central Medical Society, Headwaters Medical Society, Lake Superior Medical Society, Minnesota Allergy Society, Minnesota Society of Anesthesiology, Minnesota Society of Clinical Oncologists, Upper Mississippi Medical Society and Stearns-Benton Medical Society.

Sponsors help prevent children from starting to smoke and at the same time gain public recognition for their generosity. Posters, workbooks, and press materials are emblazoned with the names of the sponsors in each community. The theater makes scheduling and publicity arrangements.

As the *Monitor* goes to press, several other societies and clinics are considering becoming sponsors. To learn more about this exciting opportunity, call Lorrie Holmgren at the MMA at 800/DIAL MMA (800/342-5662) or 612/378-1875.

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HTAC Releases Bone Density Screening Report

The Health Technology Advisory Committee (HTAC) has released a report recommending bone densitometry for diagnosing and treating postmenopausal women who are deemed at risk for osteoporosis. The report concludes that bone densitometry is safe and provides valuable information about a woman's relative risk of suffering an osteoporosis-related fracture.

Bone densitometry screening measures bone mineral density (BMD); low BMD indicates likelihood of osteoporosis. HTAC's report qualifies its endorsement of bone densitometry by emphasizing that use of this costly technology should be reserved for women suspected to be at risk for osteoporosis.

There would be no value in screening women currently on hormone replacement therapy (HRT), the report states, since they are already being treated for osteoporosis. And postmenopausal women who are not amenable to treatment under any circumstances would derive no gain from the screening. However, women who would consent to treatment if found to be at risk for osteoporosis would benefit from the test.

The report makes several additional recommendations, including: All women, and all health care providers, should be educated about the prevention of and risk factors for osteoporosis; all health care providers should be educated on the bene-

fits and limitations of using bone densitometry in postmenopausal women; the benefits of using bone densitometry to aid in women's compliance with HRT should be studied; and a cost-effectiveness study using quality adjusted life years as the measure of effectiveness should be undertaken.

HTAC is an independent body that evaluates new and existing health technologies. Comprised of volunteers—many of whom work in health care professions—HTAC considers issues of safety, clinical effectiveness, health outcomes, and expense to determine whether benefits to patients and society outweigh risks and costs. HTAC reports its findings to the bipartisan Legislative Oversight Commission on Health Care Access. It also works in conjunction with the state commission of health and the state health department.

To obtain a copy of HTAC's "Bone Densitometry as Screening Tool for Osteoporosis in Postmenopausal Women," call HTAC at 612/282-6374. The committee also just released a preliminary report on genetic testing for susceptibility to breast cancer and is seeking final comments on that report. ♦♦♦♦♦

Carlson Backs Effort to Secure State's KidCare Allocation

Gov. Arne Carlson is supporting Minnesota's efforts to secure federal money for the KidCare program by including approximately \$2 million in his supplemental budget. The appropriation would come from the general fund.

Carlson's proposal is two-pronged. He proposes to remove the asset test (not allowed under KidCare rules) that is currently applied to children in Medicaid and MinnesotaCare, but directs the Department of Human Services to pursue the asset test under a waiver of the federal KidCare provisions. Minnesota added an asset standard (\$6,000 for a household of two) to income eligibility requirements for Medicaid and MinnesotaCare effective July 1, 1997.

The governor also is recommending a 50 percent reduction of MinnesotaCare premiums for children in families at or below 150 percent of poverty, from \$48 to \$24 annually, in an effort to expand coverage to

more children.

Recent remarks by officials from the Health Care Financing Administration indicate that Carlson's proposal to expand coverage by reducing premiums is not a feasible option. To secure access to the federal dollars, Minnesota may have to pursue an expansion of eligibility. Raising eligibility from 275 percent to 276 percent of the poverty level is one proposal that has received significant attention.

The KidCare legislation, part of the Balanced Budget Act of 1997, created block grants to allow states to initiate and expand health coverage for low-income, uninsured children. But some of its provisions—meant to prevent states from using the funds for unrelated purposes—are so narrow as to be unintentionally punitive for states like Minnesota, which has worked for years to provide health coverage for low-income kids under MinnesotaCare. ♦♦♦♦♦

Contracting continued from page 33

"This is an exciting opportunity," said Franklin. "With this document we can look together at one consistent agreement, and use that to educate physicians about specific contract terms and provisions—and how those terms and provisions can impact their ability to access and treat patients."

Registration for the seminar is \$25. For more information about the Model Managed Care Medical Services Agreement, contact Franklin; to register for the seminar, ask for Vicki Westling. The telephone number at the MMA is 612/378-1875 or 800/DIAL MMA (342-5662). ♦♦♦♦♦

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LEGAL NEWS

RULING: NONPHYSICIANS CAN PERFORM SCHOOL BUS DRIVER EXAMS

The state Department of Public Safety has six months to decide how to proceed following an administrative law judge's ruling that existing state law permits chiropractors and other nonphysician health care practitioners to perform physicals and sign examination certificates for school bus drivers. It has been the position of the MMA and of DPS that performing these physicals demands the ability to diagnose the presence or absence of a variety of medical conditions, and that Minnesota scope of practice laws require that school bus driver physical exams be conducted by physicians.

Patricia Franklin, MMA director of legal affairs, said the DPS has several avenues of appeal. "We anticipate continued participation in the process," she added.

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WISCONSIN COURT: COVERAGE DENIAL 'ARBITRARY AND CAPRICIOUS'

A federal district court in Wisconsin ruled that a health plan's decision to deny coverage for the cost of a feeding tube and nutrients for a patient who was unable to swallow was arbitrary and capricious under the Employee Retirement Income Security Act.

In *Schneider v. Wisconsin UFCW Unions and Employer Health Plans*, the judge rejected as "bizarre" the plan's argument that the tube and nutrients were not covered because a plan provision described "food outside the hospital" as not medically necessary.

The judge also rejected the plan's argument that the tube was not medically necessary because it was not treating the patient's primary injury to his brain.

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MEDICAL ASSOCIATION OF GEORGIA SUES HEALTH PLAN

The Medical Association of Georgia (MAG) filed suit against Blue Cross & Blue Shield of Georgia, alleging that the reimbursement rates in Blue Cross contracts are based on an arbitrary, secret system determined unilaterally by Georgia Blue.

Before July 1997, the Blues reimbursed based on usual and customary charges. But since July, the MAG alleges, Blue Cross & Blue Shield has lowered reimbursement rates in unspecified amounts that often vary from month to month, with no explanation.

The MAG is asking the Blues to establish more systematic reimbursement rates so physicians can be fully informed when deciding whether or not to participate.

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ANNOUNCEMENTS

DR. WOOD HELPS LEAD MAYO FOUNDATION

Michael B. Wood, M.D., became chair of the Mayo Foundation's executive committee on January 1. Wood, an orthopedic surgeon specializing in hand surgery, is responsible for Mayo Foundation operations.

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HOSPICE ORGANIZATION PRESENTS TWO CONFERENCES

The Minnesota Hospice Organization and hospice programs in the Twin Cities will present two conferences this month at the Sheraton Airport Inn in Bloomington. The programs are designed to help hospice and other health care

professionals improve their clinical skills in end-of-life care.

- February 26: The sixth annual Gentle Journey Conference, sponsored by HealthPartners Hospice of the Lakes, HealthEast Hospice, HealthSpan Hospice, and Methodist Hospital Hospice, will teach strategies to help patients and families find hope and meaning at the end of life.

- February 27: Making a Difference: The Team Approach to Pain Management will teach caregivers how to support dying patients and their families by controlling their physical, emotional, and spiritual pain.

For more information about these programs, call Daniel T. Holst,

Minnesota Hospice Organization executive director, at 612/659-0423.

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MINNESOTACARE RATES INCREASE FOR 1998

Minnesota Department of Human Services officials announced MinnesotaCare rates for 1998. The base rate will increase from \$84.40 in 1997 to \$105.92 in 1998. Several reasons were cited for the increases, including demographic changes and an overall increase in health care costs. Officials estimate that the rate hikes will have a \$14 million impact on the state's Health Care Access Fund.

MMA Declines to Support Complementary Medicine Report

The Minnesota Medical Association did not agree to sign on in support of a report completed by the Complementary Medicine Advisory Committee in December, but has indicated its ongoing willingness to participate in discussion and research of complementary medicine—and will encourage state regulators to do the same.

As of *Monitor* press time, the advisory committee's report was slated for presentation to the Legislature on January 23.

The committee and the report, said Patricia Franklin, MMA director of legal affairs, were the results of a legislative directive to study various

types of complementary medicine, review any literature examining efficacy of various types of complementary medicine, and explore how different complementary medicine occupations are currently regulated.

"We basically conveyed to the Health Department that the issues (the Legislature wanted) studied were not given the in-depth analysis they required," Franklin said.

She added that what the advisory committee aimed to present as a set of guiding principles "we really didn't view so much as neutral guiding principles as advocacy for different interest groups that were at the table."

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AMA: Doctors Need Not Buy Surety Bonds for Durable Medical Equipment

According to a January 12 memo from the American Medical Association, bond companies in New York—and possibly elsewhere—have attempted "to capitalize on a possible Medicare ruling to urge physicians who distribute any durable medical equipment to purchase surety bonds. ... The purchase of such bonds is premature." Richard A. Deem, AMA vice president for federal affairs and coalitions, sent the letter to state medical societies.

The memo explains that the Health Care Financing Administration (HCFA) is developing, as a result of the Balanced Budget Act of 1997, a proposed regulation to govern what entities are required to buy surety bonds in order to distribute durable medical equipment. According to the memo, HCFA is consider-

ing requiring anyone using a supplier ID to bill Medicare to post a surety bond.

After HCFA issues the proposed regulation there will be a comment period—but no requirement exists until the regulation is final.

Once the regulation is final, each supplier will receive notification from the National Supplier Clearinghouse regarding requirements for the bonds.

The letter warns that "if a bond is required, not all bond companies will be acceptable to HCFA. HCFA will only accept bonds purchased from companies listed on the latest revision of the Department of Treasury Circular 570 *Companies Holding Certificates of Authority as Acceptable Sureties on Federal Bonds and as Acceptable Reinsuring Companies.*"

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MMA Key Player in AMA Initiative

• • • • • THE MMA IS A KEY PLAYER in a new AMA initiative to work more closely with state medical societies. David Renner, MMA director of policy and legislation, is a member of the executive committee of the Advocacy Resource Center, which was created by the AMA to set priorities for the AMA and state societies and to coordinate their advocacy efforts.

At its third meeting in Orlando on January 6, the group set the following priorities:

- Support the national Campaign for Health Care Accountability, which may seek legislation clarifying that states can regulate health care quality even in ERISA health plans.

- Launch a coordinated education effort on end-of-life issues, including ways to comfort families, alternatives to physician-assisted suicide, and ways to deal with chronic pain.

- Promote a model contract to help physicians in managed care arrangements (see article on page 33).

- Consider evolving case law related to ERISA.

AMA staff will develop an action plan for the executive committee to consider.

Bill Would Lower Blood Alcohol Limit

A bill to tighten the state's drunk-en-driving law by lowering the legal blood alcohol limit passed the House Judiciary Committee on the second day of the 1998 legislative session.

H.F.2389—Entenza would reduce the legal blood-alcohol standard from 0.10 to 0.08. The MMA strongly supports the provision. An identical measure, also backed by the MMA, failed to pass during the 1997 session.

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'97 Membership Data Promising

.....PRELIMINARY DATA ON 1997 MMA membership shows slightly declining membership in metro-area component medical societies, rising membership in Greater Minnesota component societies, and a modest increase in overall membership.

Joe Shulka, MMA membership marketing manager, said the overall gain was largely due to a 19 percent increase in resident membership. The number of regular active members declined slightly, by 0.4 percent.

Shulka speculates that the significant increase in outstate membership may be attributed both to lower component society dues, and to a stronger desire to "stay connected" to policymaking at the Capitol.

Although membership has remained relatively flat in recent years, the 1997 numbers are viewed positively by membership staff. With the change in eligibility requirements for Midwest Medical Insurance Company insurance in early 1997, overall membership was expected to be affected negatively. An aggressive retention and recruitment effort following the benefit change helped minimize its impact.

The number of female members has risen steadily in the past several years—particularly in the reduced rate membership category, Shulka said. In 1994, 14 percent of reduced rate members were women; in 1997, 24 percent were women.

The change may be part of a larger trend, in which many professionals are choosing part-time arrangements while raising families or pursuing other personal interests.

MMA Continues Work with Hepatitis C Coalition

The MMA continues to be an active participant in the Hepatitis C Coalition, which met again January 14. MMA health policy analyst Janet Silversmith attended that meeting.

The group is in the midst of a statewide effort to heighten awareness and expand testing of at-risk individuals for the hard-to-detect disease.

A brochure that provides general information about Hepatitis C has been published by the coalition and is

available in three languages: English, Spanish, and Hmong. To obtain free copies for display in exam rooms or patient waiting areas, contact Mark Schiffman at the coalition at 612/831-3200.

The coalition also has created a Minnesota Hepatitis C Helpline; callers can obtain answers to questions, referrals to specialists by ZIP code, and Hepatitis C information kits. The Helpline number is 800/428-7425.

MMA Alliance Prepares for North Central Regional Conference

The Minnesota Medical Association Alliance is gearing up to host the first-ever North Central Regional Conference, scheduled for March 5 and 6 at the Kahler Plaza Hotel in Rochester.

The Alliance has been planning the event with alliance organizations from 11 other state medical societies in the North Central Region: Illinois, Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin, said Karen Tourdot, MMA executive director.

An extensive tour of Mayo Clinic and a forum for exchanging ideas are slated during the two-day conference. Organizers hope the North Central Regional Conference will become an annual event, hosted by a different member state medical society alliance each year, Tourdot said.

The conference was timed to coincide with a March 5 seminar on coping, sponsored by Mayo Medical Center, the Zumbro Valley Medical Society Alliance, and the Mayo Foundation for Medical Education & Research, in an effort to generate high turnout to both events. The seminar, titled "Patchwork: Putting

the Pieces Together," will be held in Phillips Hall at the Mayo Medical Center.

The Minnesota Medical Association Alliance is a nonprofit volunteer group comprised of over 1,000 spouses of physicians, resident physicians, and medical students.

The Monitor

FEBRUARY 1998

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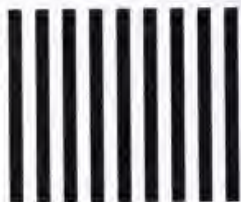
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The Poetry of Country Doctoring

A recently published book, a reissued book, and a classic short story paint the lives of country doctors.

Reviewed by Charles R. Meyer, M.D.

The poem springs from the half-spoken words of such patients as the physician sees from day to day. He observes it in the peculiar, actual conformations in which its life is hid. Humbly he presents himself before it and by long practice he strives as best he can to interpret the manner of its speech. In that the secret lies. This, in the end comes perhaps to be the occupation of the physician after a lifetime of careful listening.

—William Carlos Williams,
Autobiography

Country doctors are the stuff of romance—Norman Rockwell material. The black bag, the healing hand, the world-weary eyes. With the advent of large medical groups and larger medical corporations, the lone country doctor, whose mere presence evokes comfort and security, risks becoming a historical curiosity. But they still exist, and their professional lives are fascinating reflections of the poetry and pathos of doctor and patient.

A recently published book, a recently reissued book, and an 80-year-old short story paint the life of country doctors with reality and symbolism. "A Measure of My Days: The Journal of a Country Doctor" (University Press of New England, 1997) records a year in the life and practice of David Loxterkamp, a family practitioner in rural Maine. "A Fortunate Man: The Story of a Country Doctor" (Vintage Books, 1997), originally published in 1967 by John Berger and Jean

Mohr, is a photo essay that profiles English country doctor John Sassall. The short story "A Country Doctor" (in "The Complete Short Stories of Franz Kafka," Schocken Books, 1971) written in 1919 by Franz Kafka, uses a simple house call by a country doctor to weave a surrealist tale with realistic messages. These three stories, separated by time and geography, are wedded by themes of work and dedication in serving impoverished populations.

In the communities in Maine and England where Loxterkamp and Sassall practice, the rural poor and lower middle-class working folk scratch out lives in the stingy countryside. Both Sassall and Loxterkamp are gentlemen among proletarians, and each handles the social gap in a different way. Sassall maintains a calculated distance from the villagers, while Loxterkamp is intimately involved in church and community. Yet Sassall bridges any rift with his patients by sharing an unconventional crudity of language with them. Destitute patients often cannot pay the bills, and it's clear that these physicians struggle financially. As Kafka's doctor says, "I was badly paid and yet generous and helpful to the poor." Indeed, rural doctoring continues to be a tough way to make a buck.

Financial stresses seem meager, however, next to the burden of the country doctor's work. Each of these doctors responds differently. Kafka's physician "did [his] duty to the utter-

most, to the point where it became almost too much." For Sassall, work defines him: "He was always overworked and proud of it." And the title of his book derives from Sassall's view of work: "Like an artist or like anybody else who believes that his work justifies his life, Sassall—by our society's miserable standards—is a fortunate man." Loxterkamp, however, struggles. His journal is a meditation on the search for balance between work, home, community, and soul. He explores outlets like running, silent retreats, sabbaticals, and writing to reach equilibrium.

All three stories probe the bond of doctor and patient as the doctors seek to know their patients' souls. In classic Kafka symbolism, at the end of his story the doctor lies down next to his patient. Sassall and Loxterkamp build these relationships by listening to their patients. Loxterkamp writes, "Doctors show their respect simply by listening, by cherishing the intimate details or petty concerns that others might disregard. We do not flee the disfigured face, the stench of incontinence, the spasmodic sobbing of a jilted lover, or the litanies of complaints by those in chronic pain. We stand by. We are there." Both Sassall and Loxterkamp counsel physicians to delve beyond the headache and the hemoglobin to the life behind the pathology.

Like poetry, these stories don't lay out a "how to." They present pictures of what we might expect and



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seek in the relationship between doctor and patient. Loxterkamp's words ring truest, probably because he is coping with what most contemporary docs battle—managed care, rising overhead, too little time, too much disease, unreasonable expectations. But all three authors urge doctors, country and urban, to look for the poetry in their days. Debts, disease, and death can make the poetry hard to hear. But it's there. In the exam room.

MM

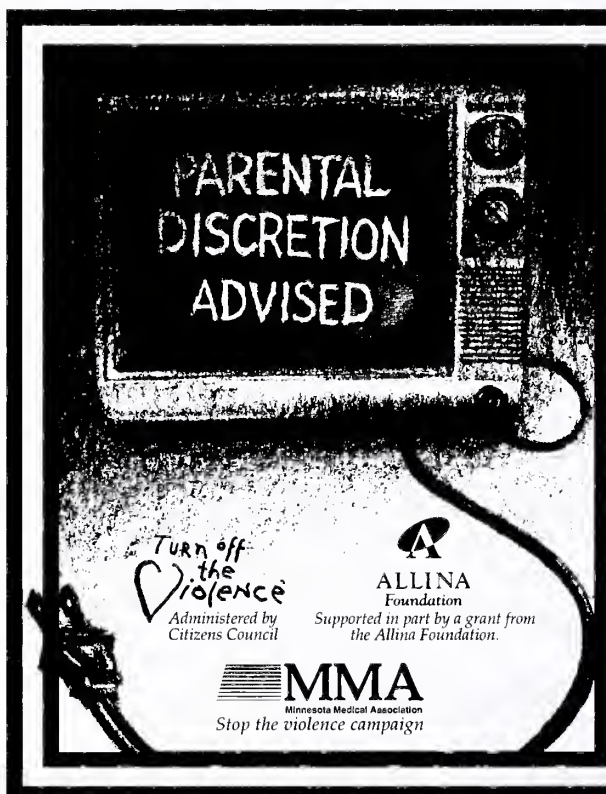
Charles Meyer is editor-in-chief of Minnesota Medicine and an internist with Consultants—Internal Medicine in Minneapolis.

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People and Places Making Medical News

People

Reinertsen Announces Plan to Leave HSM

James L. Reinertsen, M.D., president and chief executive officer of HealthSystem Minnesota, has announced his plan to leave the organization at the end of this year.

Reinertsen, a Harvard Medical School graduate in internal medicine and rheumatology who has been with HSM for 11 years, said he is considering returning to medical practice, teaching, or consulting. He expects the search for a successor to take about six months. An HSM board composed of physicians and community leaders will oversee the search.

Reinertsen also announced that David K. Wessner will become HSM's chief operating officer in addition to his current position as executive vice president.

St. Paul Ob/Gyn Wins National Medical Association Award

The National Medical Association, a Washington, D.C.-based medical organization for African-American physicians, recognized St. Paul ob/gyn Charles E. Crutchfield, M.D., for contributing the most to the association's Ob/Gyn division.

Crutchfield, an active participant in the organization for 14 years, most recently served as secretary/treasurer and is the former president of the Minnesota Association of Black Physicians. He has received numerous other awards, including the MMA's Humanitarian of the Year Award and the Ramsey Medical Society's Community Service Award.

Crutchfield was the first African-American ob/gyn to practice in Minnesota and the first to chair the ob/gyn departments at United and St. Joseph's hospitals.

In addition to his practice in St. Paul, Crutchfield has offices in

Apple Valley, Inver Grove Heights, and White Bear Lake. He lives in Central Village in St. Paul with his wife, Pat.

Fairview Lakes Leader Named

Daniel K. Anderson has been named senior vice president and administrator of Fairview Lakes Regional Health Care, a network of hospitals, clinics, and related programs serving the area northeast of the Twin Cities. Fairview Lakes is part of the Minneapolis-based Fairview Health Services. Anderson, who has held key administrative positions within Fairview Health Services since 1979, replaces Scott Wordelman, who was named chief executive officer of Fairview Red Wing Health Services.

Places

'U' Hospital Sale Pays Off

The merged Fairview-University Medical Center will at least break even in its first year, said Frank Cerra, M.D., head of the University of Minnesota Academic Health Center, at a December meeting of the university Board of Regents. If the hospital had remained under public ownership, it had been projected to lose \$20 million or more.

Cerra said that while the university experienced only a slight increase in number of patients admitted last year, it did see enough to be able to continue its accredited programs. The university has reduced the number of physicians in specialty training in recent years, and more cuts are being considered.

Some major parts of the merger are still in early stages, especially the proposed merging of the medical staffs. According to Cerra, the 400 doctors from the Medical School and the 1,500 active private

physicians involved in the Fairview system haven't yet been melded into a collaborative group.

Medical schools nationwide face the dilemma of how to finance research and education at a time when insurers are looking for ways to cut costs and the government is cutting back Medicare and Medicaid payments. Fairview personnel are still trying to figure out how to make up for millions of dollars in research revenue that will be lost because of Medicare and Medicaid cutbacks, Cerra said.

HCMC Receives NOVA Award

The American Hospital Association has chosen Hennepin County Medical Center to receive a 1998 NOVA Award for the hospital's role in forming the Glenwood-Lyndale Community Clinic. The award is presented annually to five U.S. hospitals that demonstrate commitment to their communities through collaborative projects aimed at improving the health status of community residents.

The clinic, on Bryant Avenue in north Minneapolis, serves a diverse population of Asian-Americans, African-Americans, Somali/Sudanese, and Caucasians. The clinic is a result of a collaboration between HCMC, the Glenwood-Lyndale Community Center, and other community agencies.

BCBSM, Mayo Sign Five-Year Agreement

Blue Cross and Blue Shield of Minnesota and Mayo Health System signed a five-year agreement adding five clinic sites to the BCBSM clinic network. The agreement ensures Blue Cross's position as market share leader in southern Minnesota, covering about a third of the residents.

The agreement renews Blue Cross's contracts with clinics that

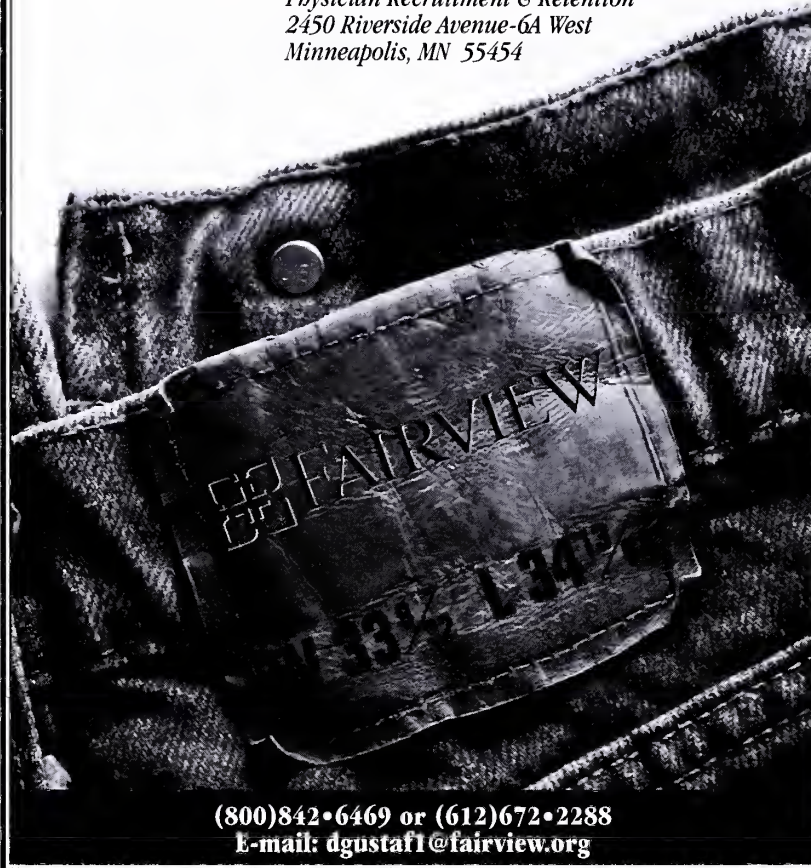
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were bought by Mayo Health System in the past five years: Fairmont, Lake City, and Wabasha clinics, and Mayo Clinic Department of Family Medicine sites in Kenyon and Kasson.

Socioeconomics

Medica Will Cover Nicotine Therapy

Starting in July, Medica, the largest HMO in Minnesota, will begin

paying for treatments to help smokers kick the habit. It will be the first HMO in the state to cover costs for nicotine patches and gum; Zyban, an antidepressant that reduces the urge to smoke; and behavior modification counseling. Medica expects to spend \$500,000 to provide the therapy for the 60 percent to 70 percent of its 200,000 smoker members who have said they are ready to quit. It's likely that members who go through the treatment will be asked to pay 20 percent of the cost.

Medica anticipates a savings of around \$21 million a year in smoking-related costs among members. But the health plan cannot predict when it will begin to see the savings, since the effects of smoking occur over long periods of time.

Mayors Pledge to Curb Teen Smoking

Thirteen Twin Cities-area mayors pledged in January to lead their communities in a fight against youth smoking. A new Minnesota law requires all cities in the state to license and annually check all tobacco merchants to ensure they don't sell tobacco products to minors. At an event sponsored by the Minnesota Department of Health and the Minnesota division of the American Cancer Society, the mayors held a formal kick-off for the law's enforcement.

"Tobacco use is the problem that's most likely to harm our young people," said Jean Harris, M.D., mayor of Eden Prairie. "Forty percent of Minnesota high school seniors have smoked, and one-third of them will die from tobacco-related illnesses. If kids smoke today, we pay the price tomorrow."

Under the new law, cities must conduct "stings," sending teenage decoys to local tobacco merchants to see if the stores sell tobacco to minors. Since Minneapolis began conducting stings in 1994, the number of merchants selling to minors has dropped significantly. Of 229 checks conducted recently

in Minneapolis, 50 underage decoys were able to purchase tobacco. In 1994, three-quarters of the stores were caught illegally selling tobacco to minors.

Rates, Trends, Data

Drug and Alcohol Abuse by Elderly Should Not Be Ignored

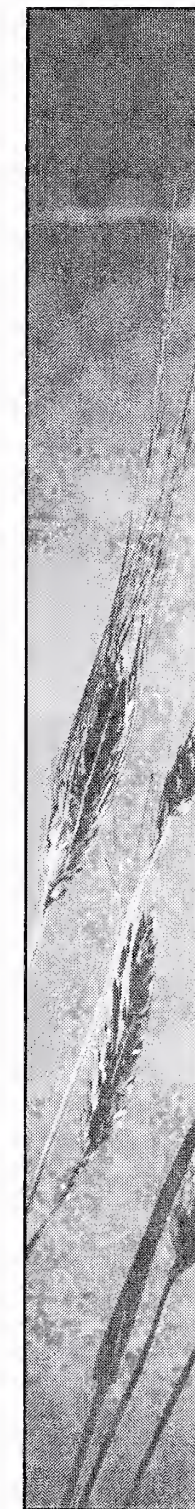
More than six of 10 Americans say they have worried about alcohol or drug use in an older person, according to a survey that the Minnesota-based Hazelden Foundation conducted to test people's perceptions about seniors and addiction. The survey also showed that many younger people, including some health professionals, tend to oversympathize with older people's alcohol or drug use, said **Carol Egan**, director of older adult services at Hazelden's Florida branch in West Palm Beach.

"We tend to overlook symptoms because of a perception that a sweet little old lady couldn't be an alcoholic. Or we believe grandma's had to give up so much already, why shouldn't she have a few drinks at night to help her sleep?" said Egan. Research shows that up to 70 percent of all hospitalized persons age 60 and over, and up to half of nursing home residents have alcohol-related problems. Often, people just don't know how to raise the issue with an older person.

Less than 6 percent of patients in treatment programs are older than 65, but people in this age group have the best track record for recovery.

State's Immunization Rates Rising, but Still Far from Goal

Immunization rates are increasing modestly in Minnesota, but the rates are far from reaching the state's goal of 90 percent by the year 2000. According to the Minnesota Department of Health, only 68 percent of children who entered kindergarten last year were fully immunized by age 2; that is, about 22,000 of 69,772 students were not fully immunized by age 2.



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Minneapolis children had the lowest immunization rate, 45 percent; St. Paul's rate of 57 percent also was among the lowest. The highest rates were in Olmsted County, 81 percent, and Blue Earth County, 80 percent. Rates in the

Twin Cities suburbs were higher than those in Minneapolis and St. Paul. For example, the rate in Edina was 73 percent and Richfield 71 percent. In Hennepin County, excluding Minneapolis, Richfield, Bloomington, and Edina, the rate

was 73 percent. In Ramsey County, excluding St. Paul, the rate was 78 percent.

Immunization rates were significantly lower among certain ethnic groups: Asian/Pacific Islanders, American Indians, Hispanics, and African-Americans. Although 72 percent of children of color received the recommended vaccinations by age 4 months, the rate dropped to 55 percent at 6 months and 34 percent at 20 months.

Costs of Alcoholism, Depression May Surpass Cancer

The medical costs of alcoholism and depression may surpass the costs of treating cancer before the year 2010, according to researchers at the Institute for the Future located in Menlo Park, California. The study, commissioned by the Robert Wood Johnson Foundation to mark its 25 years of medical philanthropy, predicts how the U.S. health care system will change by the year 2010.

Researchers said heart disease will remain the leading health problem. Alcohol dependency and depression combined will edge out cancer among the four leading burdens on the health care system. They also predict that strokes, injuries, and violence will remain significant health problems.

Information technology will become increasingly important, and people may even use the Internet to transmit blood pressure readings and other data to their physicians. Researchers also predict that more than two-thirds of the population will be in managed care before 2010, but about 15 percent of Americans will be without health insurance—about the same as today.

Medical Research

Researchers Identify Lyme Disease Genes

Researchers have identified all 1,283 genes that the Lyme disease microbe uses to infect people,

reported scientists in the December 11 issue of *Nature*. Researchers from the Institute for Genome Research in Gaithersburg, Maryland, the University of Utah, and MedImmune Inc., also in Gaithersburg, do not know what each of the genes does, but knowing where they are will help determine what they do. Proteins made by some of these genes could be the targets for vaccines or other drug treatments.

"The majority of the plasmid genes, 85 percent, are novel. They have not been seen before [in any other microbes analyzed]," said biologist Claire Frazer, who led the research team.

Innovations

U of M Researchers Devise Autoimmune Disease Therapy

University of Minnesota researchers have devised a new treatment for myasthenia gravis (MG), the muscle weakening disease that killed Aristotle Onassis and affects one in 8,000 people in the United States. The treatment essentially "tricks" the immune system into halting its attack and "tolerating" the muscle parts it had previously targeted. A pilot clinical trial may begin soon for the nasally administered therapy, which prevented the disease in mice. The study appeared in the December 15 issue of the *Journal of Clinical Investigation*.

"We concentrated on a mechanism used by our bodies to avoid mounting an immune response against everything," said biochemistry professor Bianca Conti-Fine, Ph.D., who led the study. "This mechanism prevents our bodies from getting hyperactive against everything we breathe or eat." The university has filed a patent on the therapy.

Pilot clinical trials are expected to begin at the University of North Carolina-Chapel Hill sometime early next year, said James Howard Jr., M.D., professor of neurology and head of UNC's

Division of Neuromuscular Disorders. Howard said probably four to six patients would be treated, and it would take about a year to determine the efficacy of the new therapy.

Medtronic Device Used to Treat Cerebral Palsy Patient

A device made by Fridley, Minnesota-based Medtronic designed to calm the tremors of Parkinson's patients has been implanted in the brain of a teenager with cerebral palsy, allowing him to feed himself and write letters for the first time. Jerrod Ongley is the first cerebral palsy patient treated with the Activa system, a deep brain stimulation device approved by the FDA in August.

Neurosurgeons at Children's Hospital in Pittsburgh showed a videotape of Ongley trying unsuccessfully to drink water from a cup. When the device was activated moments later, he was able to reach out and grasp the cup and drink from it. "It's going to change his life," said Ongley's mother. The doctors said the procedure will have to be tested on about 100 patients before doctors will know whether it is a dependable treatment.

The procedure, which costs about \$25,000, involves drilling through the skull to implant an electrode into the thalamus. The left side of the thalamus controls movement on the right side of the body and vice versa. A wire runs just under the scalp from the top of the head to the collarbone, where a pulse generator is implanted. The generator uses a battery to send electrical waves to the electrode, which emits 180 electrical shocks each second to block tremors. The patient can turn off the device at night to conserve the battery, which must be surgically replaced every three to five years.

MM

HAGEN *continued from page 7*

and prevention, and he is currently board certified in both.

As part of his training, Hagen spent a year in a master's program at the University of Minnesota's School of Public Health. There he learned to think about mass communication, including the importance of health messages, how a public health campaign is carried out, who's involved, and how it's measured. He is guided by the maxim that many of the gains in the health of a population have been gains in public health.

The idea of empowering individuals through education is a long-standing tradition at Mayo. C.H. Mayo, as long ago as 1932, said, "The object of all health education is to change the conduct of individual men, women, and children by teaching them to care for their bodies well."

But despite C.H. Mayo's foresightedness, concepts like wellness and self-care haven't always been part of our vocabularies. Hagen traces the current interest to changes that took place in the '70s. "Whereas previously many patients saw their doctor as all-knowing, the relationship changed to one of a partnership between the health care provider and the patient," says Hagen. Of course, a change in relationship meant a change in communication styles and methods.

Most physicians view increased patient responsibility as a positive development. When patients are more informed, physicians' lives are easier, and in the end, the quality of care is better, contends Hagen.

"No one wants to go to the doctor," he says. While the Mayo HealthQuest program is not intended to replace those visits, it is designed to make clinic visits more effective. "It's more of a pre-doctor tool," he explains. "It allows people to think, 'When I run across a problem, what do I do first?'"

Hagen's duties at Mayo are by no means limited to the Mayo HealthQuest project. He spends about 65 percent of his time in clinical practice. "If you stop practicing clinical medicine, you lose touch with people's needs—with that human view on the world."

While balancing a multitude of teaching, committee, and administrative duties, Hagen always seems to find ways to use his computer expertise. For instance, he's chairing Mayo's Electronic Medical Record—Patient Provided Information Task Force, and he is associate editor of an interactive CD-ROM series, "Prime-Practice," which provides continuing medical education for physicians.

Focused on the future, Hagen is excited about Mayo HealthQuest's plans to explore audio and video formats.

But for all his enthusiasm, his vision for the role of technology is tempered with a humanistic concern. "The computer, like the stethoscope, is a tool to assist in the care of people—person to person," Hagen says. "The challenge for medicine in the future will be to remain focused on the relationship of care provider and patient while all of the changes in technology, paperwork, and organizations are swirling around us." **MM**

Deborah Sugerman is a free-lance writer living in Minneapolis.

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TALK TO ME *continued from page 11*

and make it personal again. When my father's father died in the French Quarter of New Orleans 60 years ago, the popularly accepted story was that on a humid night in mid-August, he had eaten a dozen bananas and then taken a cold bath. He was a man of 87 whose life had been a strenuous assertion of his appetites, and this explanation suited him, just as it suited his friends in the French Quarter. It would be more satisfying to me, it would allow me to feel that I owned my illness, if my urologist were to say: "You know, you've beat the hell out of this prostate of yours. It looks like a worn-out baseball." Nobody wants an anonymous illness. I'd much rather think that I brought it on myself than that it was a mere accident of nature.

It is only natural for a patient to feel some dismay at the changes brought about in his body by illness, and I wonder whether an innovative doctor—again, like Oliver Sacks—couldn't find a way to reconceptualize this situation. If only the patient could be allowed to see this illness as not so much a *failure* of his body as a natural consumption of it. Any reconciling idea would do. The doctor could say, "You've spent your self unselfishly, like a philanthropist who gives all his money away." If the patient could feel that he has earned his illness, that his sickness represents the decadence that follows a great flowering, he might look upon the ruin of his body as tourists look upon the ruins of antiquity. (Of course I'm offering these suggestions playfully, as experiments in thinking about medicine.)

Physicians have been taught in medical school that they must keep the patient at a distance because there isn't time to accommodate his personality, or because if the doctor becomes "involved" in the patient's predicament, the emotional burden will be too great. As I've suggested, it doesn't take much time to make good contact, but beyond that, the emotional burden of avoiding the patient may be much harder on the doctor than he imagines. It may be this that sometimes makes him complain of feeling harassed. The patient's unanswered questions will always thunder in his stethoscope. A doctor's job would be so much more interesting and satisfying if he would occasionally let himself plunge into the patient, if he could lose his own fear of falling.

Applying to other friends, following new recommendations, I found another urologist. He's highly regarded in his field, and he inspired such confidence in me that my cancer immediately went into remission. My only regret is that he doesn't talk very much—and when he does, he sounds like everybody else. His brilliance has no voice—at least not when he's with me. There's a paradox here at the heart of medicine, because a doctor, like a writer, must have a voice of his own, something that conveys the timbre, the rhythm, the diction, and the music of his humanity, that compensates us for all the speechless machines. When a doctor makes a difficult diagnosis, it is not his medical knowledge only that determines it, but a voice in his head. Such a diagnosis

depends as much on inspiration as art does. Whether he wants to be or not, the doctor is a storyteller, and he can turn our lives into good or bad stories, regardless of the diagnosis. If my doctor would allow me, I would be glad to help him here, to take him on as my patient. Perhaps later, when he is older, he'll have learned how to converse. Astute as he is, he doesn't yet understand that all cures are partly "talking cures." Every patient needs mouth-to-mouth resuscitation, for talk is the kiss of life.

Yet it's too easy to accuse the doctor, to blame the absence of natural talk on him. It's also true that some of what the patient asks is ineffable. Even a doctor like Chekhov would be hard put to answer him. For example, I would like to discuss my prostate with my urologist not as a diseased organ but as a philosopher's stone. Every patient invites the doctor to combine the role of the priest, the philosopher, the poet, the scholar. He expects the doctor to evaluate his entire life, like a biographer.

Of course, a physician may reasonably ask: "But what am I supposed to say? All I can tell the patient is the facts, if there are any facts." But this is not quite true. The doctor's answer to his patient is yet to be born. It will come naturally—or at first unnaturally—from the intersecting of the patient's needs with the physician's as yet untried imagination. Just as a mother ushers her child into the world, so the doctor must usher the patient out of the ordinary world into whatever place awaits him. The physician is the patient's only familiar in a foreign country.

To help the doctor reach the patient, and the patient reach the doctor, the mood of the hospital might have to be modified. It might be less like a laboratory and more like a theater, which would be only fitting, since no place contains more drama. The laboratory atmosphere can probably be traced back to the idea of asepsis, to the avoidance of contagion. Originally, the patient was protected by the sterility of the hospital. Only the sterility went too far: It sterilized the doctor's thinking. It sterilized the patient's entire experience in the hospital. It sterilized the very notion of illness to the point where we can't bring our soiled thoughts to bear on it. But the sick man needs the contagion of life.

Not every patient can be saved, but his illness may be eased by the way the doctor responds to him—and in responding to him, the doctor may save himself. But first he must become a student again; he has to dissect the cadaver of his professional persona; he must see that his silence and neutrality are *unnatural*. It may be necessary to give up some of his authority in exchange for his humanity, but as the old family doctors knew, this is not a bad bargain. In learning to talk to his patients, the doctor may talk himself back into loving his work. He has little to lose and much to gain by letting the sick man into his heart. If he does, they can share, as few others can, the wonder, terror, and exaltation of being on the edge of being, between the natural and the supernatural. MM

Anatole Broyard, a former editor of *The New York Times Book Review*, died in 1990. © 1990 by *The New York Times Company*. Reprinted by permission.

INSIGHT *continued from page 13*

interrupted impatiently. "You've had floaters and flashing lights. Is that correct?"

"Yes," I replied, avoiding any editorializing. I am a quick learner.

"Put your forehead here," he instructed. Moving around his lights and lenses, he peered into my eyes, all the while addressing cryptic dictation to the young woman. Unconnected phrases were alternately frightening and baffling. "Lens opacity." "Stone." "PVD." "Pressure." Finally, one that was reassuring. "Retina normal." The examination then abruptly changed. "Lie down here," he said, indicating an examination table. He began a series of very firm pokes, using a cotton-tipped swab. Was the swab poking into my eyeball? Because of the anesthetic he had applied, I couldn't tell—and he certainly had no intention of informing me. What would he do next? "Sit up," he commanded. "Well," he said, gazing at a point over my head, "there is no retinal damage. So everything is fine. But to play it safe, I'd like to check you again in one month."

Not exactly fine, I thought. I still had the vision of someone snorkeling in dirty water. "Is there nothing to be done for these floaters?" I asked timidly.

"No. We could drain the vitreous, but it is very risky and you could lose your sight." He started to turn away. My plan to ask about a procedure I had found described in the *British Journal of Ophthalmology* to treat vitreous floaters with neodymium:yttrium-aluminum-garnet lasers suddenly seemed widely impractical.

"Thank you," I replied with reflexive politeness. I got off the table and stumbled toward the waiting room. There, the dim outline of my husband appeared, as welcome as a familiar landfall after hours lost at sea.

"Everything all right?" he inquired.

"My retina is fine." I paused to consider. "And I learned a lot."

"About your eyes?"

I took his arm for support. "About being a patient. ... Let's go home." MM

Mary Moore is a rheumatologist in the division of rheumatology at the Albert Einstein Medical Center in Philadelphia, Pennsylvania.

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Location: United Hospital, St. Paul

20-21 ADVANCED TRAUMA LIFE SUPPORT

Presented by: Allina Health System

Location: United Hospital, St. Paul

21 PRINCIPLES OF DIABETES MANAGEMENT

Presented by: Allina Health System

Location: Hutchinson Area Health Care, Hutchinson

MAY, 1998

13 PRINCIPLES OF DIABETES MANAGEMENT

Presented by: Allina Health System

Location: Cambridge Medical Center, Cambridge

29-30 CREATING A LATEX SAFE ENVIRONMENT

Presented by: Allina Health System and

ELASTIC, Inc.

Location: The Northland Inn, Brooklyn Park

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

FEBRUARY 1998

Feb. 6-7 **Fourth Annual Winter Conference** Minnesota Academy of Family Physicians; Arrowwood—A Radisson Resort, Alexandria, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426-1201; 612/542-0130 or 800/999-8198.

Feb. 19-20 **Burn Care Today: Accurate Assessment and Appropriate Management** Burn Center at Regions Hospital, Department of Surgery at Regions Hospital, and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Feb. 26-28 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 27-Mar. 1 **Current Concepts of Erectile Dysfunction: Diagnosis and Treatment** Mayo Foundation; Caribe Royale Resort Suites, Lake Buena Vista, FL. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1998

Mar. 8-11 **Neurology in Clinical Practice** Mayo Foundation; Silvertree Hotel and Wildwood Lodge, Snowmass Village, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-13 **Selected Topics in Internal Medicine** Mayo Foundation; Maui Prince Resort, Maui, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 12-13 **Family Medicine Today** Family Medicine Department at Regions Hospital and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for

Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 20 **1998 Emergency Medicine Conference** St. Mary's/Duluth Clinic Health System; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Diane Torvick, 400 East Third Street, Maildrop 5AV2ME, Duluth, MN 55805.

Mar. 20 **Nineteenth Annual Occupational Medicine Update** HealthPartners Institute for Medical Education; Sheraton Metrodome, Minneapolis, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

Feb. 17-20 **Infectious Diseases** MeritCare Health System; Grouse Mountain Lodge, Whitefish, MT. CONTACT: Cheri Rodenburg, MeritCare Critical Care Services, 720 Fourth Street North, Fargo, ND 58122; 800/437-4010, ext. 6913.

May. 8 **Emerging Infections in Clinical Practice** University of Minnesota; Minneapolis Airport Marriott, Bloomington, MN. CONTACT: Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 23 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Mar. 20-21 **Advanced Life Support in Obstetrics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

Mar. 29-Apr. 3 **Advanced Management Program for Healthcare Executives** University of Minnesota Carlson School of Management and Mayo Clinic; Leighton Auditorium, Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

A P R I L 1 9 9 8

Apr. 3 **ENT Update** HealthEast, Regions Hospital, and HealthPartners Institute for Medical Education; St. Joseph's Hospital, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Apr. 3-4 **Ob/Gyn Update** Ob/Gyn Department at Regions Hospital and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Apr. 6-8 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; Scottsdale Princess Resort, Scottsdale, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 16-17 **Critical Care 1998** Critical Care Department at Regions Hospital and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Apr. 16-18 **Fractures and Dislocations of the Wrist, Elbow, and Shoulder** Mayo Foundation; Pointe Hilton Resort on South Mountain, Phoenix, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 17 **Depression and Mood Disorders: Treating Today's Woman** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

Apr. 17-18 **Youth and Sports: Contemporary Issues for the Primary Care Physician** Children's Health Care; Madden's Resort, Brainerd, MN. CONTACT: Betsy Julius, Medical Education, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-5884.

Apr. 23-24 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 24-25 **Neuroscience Summit: What's New Today and Looking to the Tomorrows** St. Luke's Hospital and Regional Trauma Center; Holiday Inn, Duluth, MN. CONTACT: Cheryl Jurek, Education Department, 915 East First Street, Duluth, MN 55805; 218/726-5449.

M A Y 1 9 9 8

May 5-8 **Fifth International Surgical Pathology Symposium** Mayo Medical Laboratories; Munich, Germany. CONTACT: Kathy Bates, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; E-mail: Kbates@mayo.edu, fax 507/284-4542, fax on demand 800/263-6296 or 507/282-0461.

May 15 **Medical Management of the Surgical Patient** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

May 15-16 **John I. Coe Symposium and MSP Meeting (Pathology)** Hennepin County Medical Center; Radisson Hotel South, Bloomington, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

May 22 **Poisonous Mushrooms** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education, 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

May 30 **Critical Care: A Team Approach** Mayo Foundation; Mayo Clinic, Phillips Hall, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.



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Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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Physician Opportunity: Minneapolis/St. Paul, Duluth, and Moorhead, Minnesota; MD wanted for part-time hours in multidisciplinary office. All inquiries to Integrated Health-Care Services, doctor's private line, 612/386-6908. (1/98-R)

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MARCH 1998

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Loss of autonomy and frustration with managed care are turning some doctors into card-carrying members of the AFL-CIO.

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The Union Drama Unfolds

Who can control their fate?

—Shakespeare, "Othello"

Physicians are control freaks. Their premed personalities lead them to choose a profession reputed to assure societal prestige and secure income. Their training indoctrinates them with the perils of botched surgery and missed lab values. For those in practice, lawsuits threaten the unvigilant who neglect to monitor the thousands of details of daily doctoring. Yet, like Othello, they find they are more



.....
"When doctors form unions, the question of who should decide the course of care is pivotal."

manipulated than manipulator. Each year brings more Medicare directives and more managed care meddling. Reclaiming control is what this issue's topics—physician unions and hospitalists—are all about.

Who does control medical care? Most of us likely would respond "government and corporations via managed care." After its first few years, Medicare realized that the blank check cost a lot. Since then, we've seen utilization review, DRGs, RBRVS, and now, the dreaded E+M codes—all designed to tamponade the fiscal hemorrhage and save Medicare. Corporate America bought managed care to wire the jaws of gluttonous health benefit budgets. Since Paul Ellwood's Big Bang in 1972, we've seen an alphabet soup of managed care organizations with their cycles of consolidation, price low-balling, deficit-triggered restrictions, and provider and consumer reaction. This is why Michael Scandrett, director of the Minnesota Council of Health Plans, profiled on page 4, has a job.

This is also why the noise of doctor union talk is at an all-time high. Any frequent visitor to the doctors lounge knows there has never been a moratorium on griping. But it seems a critical threshold has been reached. Ten formularies, nine referral processes, 20 daily "medically unnecessary"

denials, and 50 percent discounts add up to an M.D. misery index. As 60 percent of new physicians join the salaried ranks, unions become not only politically attractive, but also legally possible. The phenomenon, as described in our cover story (page 10), is local and national. Even as inveterate a union opponent as the AMA has formed a division of representation and its *AMNews* runs articles like this one from October: "Employed physicians: Is it time to think about a union?" This is serious.

The hospitalist movement is another symptom of lost control. Managed care megaliths like hospitalists because they promise efficient, rationalized care. Hospitalist doctors like the arrangement because it offers a high-tech, intensive hospital practice and a predictable schedule. Doctors using hospitalist services like them because they maximize office efficiency, minimize call, and control lifestyle.

And patients? There's the crucial question about hospitalists and unions. For patients, the hospitalist arrangement means that when they are sickest, they lose contact with the physician they know best. Some say it's more important to have a doctor in hospital full time who "stays on top" of your case, but I worry about what gets lost when patients transfer doctors.

To patients, the physician union movement may seem like greedy doctors clinging to their mega-incomes. (Meanwhile, professional athletes provide the ludicrous example of \$5-million-a-year stars being represented by a union. What would Samuel Gompers think?) Although money is important in doctors' move to form unions, the patient-centered question of who should decide the course of care is pivotal.

Ironically, all of the actors in this drama claim to want the same thing: quality care at a reasonable cost. But who decides and controls what's "reasonable"? Indeed, is the medical care system controllable, or are we all destined to be manipulated by the lags of advancing technology and an aging populace? The fate of Medicare, managed care, doctors, and patients hangs on the resolution of that plot.

.....
 —Charles R. Meyer, M.D., Editor-in-Chief

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1975-1990

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1971-1974

Carl O. Rice, M.D.
1961-1970

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An

INSIDE JOB

Michael Scandrett went from the center of Minnesota's health care reform efforts to a central role with the state's health plans. Odd move? Not at all, says Scandrett, who now works to reform the system from the inside.

When Michael Scandrett accepted an offer to become the first executive director of the Minnesota Council of Health Plans two years ago, he wasn't looking for a traditional trade association job. He did not sign on to be a defender of the status quo or an apologist for the managed care industry. Rather, he and the council's health plans agreed he would continue his efforts as a reformer.

Still, in the two years since he's been at the council's helm, Scandrett has been called on to defend the system, most recently in the aftermath of the Twin Cities-based *Star Tribune's* six-part series on managed care. The series took the state's biggest health plans to task for everything from penny-pinching reflexes to muscling in on medical decisions and denying patient demands.

That's a lot to defend, but Scandrett is willing to do it. In fact, he has seized the opportunity to use the bruising series as a catalyst for community discussion on health care priorities—a discussion he says is long overdue. The community needs to have a better understanding of health care, he pointed out during a recent interview on a busy day that would include his testifying before a legislative committee looking into new delivery models for state-sponsored health care plans. “Right now there's very little understanding out there,” he says.

Scandrett is well-positioned to generate that understanding, say those who know him. “Mike's role as executive director of the Health Care Commission was a very visible example of his ability to take complex

problems and systems, ... break them into pieces, and put them back in a way that created buy-in, support, and collective vision,” says Andrea Walsh, a senior vice president at HealthPartners and chair of the Council of Health Plans' policy committee. “He's a consensus builder.”

When Scandrett was brought on board he was already one of the community's highly regarded health policy leaders. He had just completed a two-year stint heading up the Minnesota Health Care Commission, where he stayed until he felt the state's health care reform efforts were underway. The commission was an outgrowth of the health care reform law, which Scandrett also had a hand in shaping.

Scandrett's move to the private sector after years of working in the public arena could be construed as a softening of his reformist tendencies, but he says it's not. His mission at age 43 is unchanged from when he worked as executive director of the Minnesota Health Care Commission, or his earlier role as legislative staff person for the “Gang of Seven,” the bipartisan group of legislators that fashioned the health reform legislation that led to MinnesotaCare.

“I have continued to work on the same issues and with the same mission I've always had,” insists Scandrett, who turned his energy to the public arena immediately after receiving his law degree from the University of Minnesota in 1982. “What I've been working on for 20-plus years is a system that balances affordability with what people truly need from a health care system, and what the values of the community are for how that money should be spent. The health care system should be responsive to community values.”

If part of his mission is to change the system, the other part is to explain it. “What motivates me is that there's such a disconnect between the reality of what's happened and at least the media perception of people's attitudes about it,” says Scandrett, who sounds somewhat perplexed, even a bit hurt, by the negative tone of the *Star Tribune* series. He points out that despite all the

bad press, survey after survey reveals that Minnesotans give high marks to their health plans. "We have a state full of people whose personal experience with their health plan has been very positive, who feel good about their health plan. Then you have all this other anecdote-driven stuff going on in the media and at the Legislature. To me that says we have a serious education mission to fulfill."

Had Scandrett written those news stories, he might have explained how far the system has come. For example, 20 or 30 years ago quality wasn't measured, prevention wasn't covered, and patient trends and outcomes weren't monitored to bring best practices and research-based treatment into the system.

Still, he concedes that the system is far from perfect. Scandrett's goal is to achieve a system in which quality remains high, cost issues have been resolved, and everybody has access to care. "That should be a given, but we're not there yet," he says. "Our society has not yet wrestled with those issues. We have not resolved the issue of how much we can afford to spend on health care, how to achieve a fair and universal health care system, and where we should spend our money."

Scandrett is sympathetic to both consumer and physician anxiety about health care delivery. On a personal note, he recalls the anxious time he and his wife spent following the birth of their daughter, AnnaLaura, now age 12, who weighed just under 2 pounds at birth. It was a stressful time for both him and his wife, Robin, who runs a day-care center out of their home in south Minneapolis, but the experience confirmed his commitment to the ideals of health care reform.

"The experience was eye-opening," says Scandrett. "Our HMO treated us wonderfully. We had the best doctors and nurses, and we paid virtually nothing out-of-pocket, despite bills totaling six figures. But we also met parents of a newborn

with multiple disabilities who had no insurance and faced financial devastation as a result of their child's birth. And in the other beds lined up next to AnnaLaura's were premies who were born early because of [maternal] alcohol abuse, lack of prenatal care, and poverty-related health problems. The contrasts were striking."

Scandrett believes physician frustration with the health care system could be eased through a better understanding of how and why health plans operate the way they do. "I think medicine is going through a very difficult transition as a profession," he says. "Physicians are suddenly faced with the economic realities of health care, and that has all kinds of effects for them. But I really believe that if I could take any of those physicians with me for a week—take them out to meet the medical directors of the health plans, walk them through how medical policy is made, have them meet the researchers that look at best practices—they would come away with a much higher level of understanding and comfort."

He may not be going one-on-one with physicians in this fashion, but the council is engaged in a number of initiatives to create a better understanding of managed care and also to make life easier for physicians under the new system. One of those projects, EQUIP (Ethics, Quality, Information, Prevention), has brought community leaders together to role-play as health plan decision-makers. EQUIP ethics leadership forums give outsiders a

feel for the difficulty and complexity of the issues health plans face.

EQUIP is also a way for the council to hear from the community. "We want people to tell us how they would do it differently if they were running a health plan," Scandrett says. "This is everybody's system." EQUIP plans to gather community and consumer input on health plan quality and to work to improve quality and quality assessment measures. In addition, it will seek input from public health agencies and community orga-



PHOTOGRAPH BY JOHN NOLTNER

MMA and Health Plan Council Form Liaison Group

The Minnesota Medical Association and the Minnesota Council of Health Plans have formed a liaison working group to accomplish shared goals. In January, at one of the group's first meetings, MMA senior officers and representatives from the council discussed joint projects, such as development of a statewide credentialing program that all health plans would use.

"All parts of the health care system need to work together on improvements," says Michael Scandrett, executive director, Minnesota Council of Health Plans. "The liaison group was formed because both health plans and physicians realize that we need each other. Health plans want to understand the problems physicians face so that, when possible, we can help resolve them. The liaison group provides a venue to understand each other better, work through issues, and develop concrete solutions."

One ongoing goal of the liaison group will be to encourage active physician membership in organized medicine. Although it's not the case for Minnesota, organized medicine nationally has experienced a decrease in membership among managed care phy-

sicians. "The liaison group would like to see more physicians from large health plans involved in MMA decision-making," says Paul Sanders, M.D., MMA chief executive officer. "One possibility is to thoroughly integrate health plan medical directors into MMA activities by creating a medical directors' section or a physician executive section."

To help keep managed care physicians interested in organized medicine, the liaison group suggested discussion on such issues as quality improvement and outcomes research; collaboration to achieve public health goals; and joint CME activities.

The liaison group also discussed the possibility of working together to achieve goals set in resolutions adopted by the Minnesota House of Delegates. MCHP expressed interest in recent MMA resolutions to study health plan liability, contract education, and health plan pricing strategies. The MMA invited MCHP to suggest physicians to participate on the MMA's task force to study antimicrobial prescribing practices, which the 1997 MMA House of Delegates established to advise the MMA Board of Trustees.

The group's next meeting is set for March 12.

nizations on how health plans can improve prevention.

Council projects designed to make the physician's life easier focus on standardization of certain forms and routines. For example, last year the council produced a pocket-sized outpatient formulary guide, indicating which drugs are covered by which health plans, and created a standard credentialing form that all health plans will accept. It also developed a standardized pregnancy risk-assessment checklist that reminds physicians of questions to ask when talking to a pregnant woman and provides information on reducing risk. An accompanying manual includes community resources and medical research references.

Later this year the council will release an easy-to-read report for consumers outlining the strengths and weaknesses of different health plans. And it has begun working with the Minnesota Medical Association on several major projects (see the sidebar above), including

an effort to develop standardized credentialing that all health plans would use.

These efforts will pay off, Scandrett promises. "It's going to take years for people to adjust to this new era of health care, but I'm optimistic that within a few years we'll have a much higher level of understanding of the health care system. We'll continue to see improvements that will make the system work better. We're already so much better off than we were 10 or 20 years ago in terms of coping with costs, providing coverage to people who don't have insurance, monitoring and improving quality, and shifting more emphasis to prevention," he says.

"I think we'll get through it. It will take time and a lot of public discussion and a lot of pain. But we've got to stop pointing fingers and work together." **MM**

Miriam Karmel Feldman, a free-lance writer in Minneapolis, is a frequent contributor to Minnesota Medicine.



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FROM THE DESK OF
RICHARD L. REECE, M.D.

Health care pundit, pathologist, and editor emeritus Dick Reece offers his observations about Minnesota's place in the national health care picture.

Dear Minnesota Physicians:

I left the *Minnesota Medicine* editorship in 1990. Perhaps it's a delayed seven-year itch, but I feel the urge to communicate with Minnesota physicians again. I thought your readers might be interested in what I'm doing now and how I view Minnesota in the context of the national health care picture.

I miss Minnesota and my friends there. That Minnesota regularly ranks No. 1 among the states in health status is a tribute both to its citizens and its health system.

Six years ago, while practicing in Oklahoma, I founded the National Association of Physician Hospital Organizations (NAPHO). In 1992 PHOs looked to me like a logical bridge from unstructured health care markets, as in Oklahoma, to more mature markets like Minnesota's. I thought of PHOs as a reasonable local partnership between hospitals and physicians to deal with managed care constructively.

For the most part, I was wrong. With a few notable exceptions, such as North Memorial Medical Center in Robbinsdale, PHOs have proven dysfunctional because of inherent management, economic, and cultural conflicts between hospital executives and physicians. Another factor is that health plans often regard PHOs as rivals and protectors of the status quo. The second generation of PHOs has been more successful than the first, but PHOs remain a weak model for advancing physicians' economic causes.

In 1995 NAPHO changed its name to the National Association of Integrated Health Organizations (NAIHO), which encompasses PHOs, IPAs, MSOs, group practices without walls, and integrated delivery systems. These organizations, particularly when led by impartial physicians seeking financial equity (or by integrated medical groups seeking capital) and operated independently of but collaboratively with hospitals, remain the best hope for an effective health system. In Nashville in late September, NAIHO sponsored the National Congress for Financing Healthcare Organizations, which attracted more than 300 investors, physician groups, and health industry leaders, who

came to learn about consolidation, capitalization, and different structural options for health care organizations.

One thing's for sure: the days of "command and control" hospital systems are over. Running a hospital and running a group practice require different competencies, which is the major reason vertically integrated hospital systems with salaried physician employees are on the wane. The center of the health care universe continues to migrate away from hospitals to physicians' offices, and this migration is creating a new generation of physician leaders and organized groups that are increasingly capable of assuming and subcontracting risk.

Two years ago, I became the editor-in-chief of *Physician Practice Options*, a monthly newsletter with a circulation of 150,000. Our newsletter does not take a stand for or against managed care. We simply regard it as mainstream medicine. Our editorial mission is to provide objective information to help physicians succeed in managed care. We focus on making the transition from traditional practices to managed care; raising capital; forming groups to qualify for capital; finding suitable capital partners; determining what kinds of organizations are sustainable; building infrastructure; taking physician groups public; and strengthening physicians in the marketplace. To be competitive in managed care markets, to gain new managed care contracts, to hire managed care expertise, and to evaluate and buy adequate information systems, physicians need capital.

One feature of our newsletter is a hotline that reaches my office. Every day I talk to physicians around the country who tell me about their business concerns and ambitions. They are concerned about survival—they hope to form competitive organizations in which they have equity and in which they can practice their own brand of managed care.

In 1987 I published a book, "And Who Shall Care for the Sick? The Corporate Transformation of Medicine in Minnesota," a collection of my *Minnesota Medicine* editorials. In the book, I correctly predicted the triumph of managed care over independent practice, the dominance of large integrated oligopolies, and the threat to the University of Minnesota Medical School and its hospital.

But I missed a few things—I didn't foresee the decisive influence of the Business Health Care Action Group, the growing weakness of vertically integrated delivery systems and staff model HMOs, and the emergence of point-of-service plans as consumers demanded direct access to specialists. I definitely didn't anticipate that United Health-Care would become the largest managed care organization, with

LETTER continued on page 50



DOCTOR?

IS A QUESTION FOR YOU

He prefers to remain unnamed, but he and many other orthopedists in Tampa, Florida, are fed up with managed care plans. "They promised us volume in return for efficiency," he says. "We delivered; they didn't. Instead, we got one reimburse-

ment cut after another to where it's hard for some of us to meet overhead. Quality of patient care was going down. Salaries were going down. Hospital utilization was going down. The only winners were insurance companies. So we said screw it, joined a union, and refused to renew our contracts."

Trails of broken promises, delays and denials, take-it-or-leave-it attitudes—sounds like a dreary he-don't-me-wrong song. But the too-familiar tune is turning doctors into card-carrying members of the AFL-CIO.

Not that there's a stampede to the union gates. The AMA estimates that only 3 percent of practicing physicians have joined unions, though no one knows for sure, according to Grace Budrys, Ph.D., a sociologist at DePaul University in Chicago and author of the book "When Doctors Join Unions" (see book review, page 43).

"Meaningless figures are bandied about," she says. "Suffice to say, interest in unions is really taking off." An assortment of national labor unions are competing for doctors like straw-hat carny barkers—and for good reason. Unions help employed physicians bargain collectively, and they help independent physicians negotiate contracts by serving as savvy third-party messengers.

Most unionized physicians are dues-paying members of large national labor unions, including some physician unions. One of the oldest is the Union of American Physicians and Dentists (UAPD), formed in the 1970s during an era of active unionization efforts. UAPD, based in Oakland, California, and affiliated with the American Federation of State, County and Municipal Employees, has grown to a membership of about 5,000 physicians, mostly in California. The Federation of Physicians and Dentists, a physician union headquartered in Tallahassee, Florida, has a membership of about 7,500, around 3,000 of them physicians. And the Office and Professional Employees International Union created the National Guild for Medical Providers in 1996 to attract independent physicians and other providers. Its 15,000 members include 3,200 physicians and all podiatrists in 16 states.

Some physician groups choose to form their own unions, which often cease to operate once a specific

grievance has been resolved. According to Budrys, of the 20 unions formed in the 1970s and '80s, only one still exists.

The physicians employed by Medical West Associates in Springfield, Massachusetts, are a good example. Outrage over a single incident prompted the 80 physicians to form New England's first independent, local physician union. Blue Cross and Blue Shield was about to sell nine clinics with no say from the doctors employed by the clinics. "We were viewed as no more important than tables and chairs that could be bought and sold," says Robert Lounsbury, M.D., a Medical West internist and union president.

Blue Cross and Blue Shield was legally obligated to include Medical West in negotiations once the physicians armed themselves with collective bargaining power. The doctors helped hammer out terms and choose a buyer—for-profit MedPartners of Birmingham, Alabama. As part of the deal, the doctors formed a professional corporation, which made them stockholders and partners with MedPartners.

"This puts us in a stronger position than the union did," says Lounsbury. "We had a problem. We formed a union to solve the problem, and now the concept of a union doesn't appeal anymore. We've moved on to other things and no longer function like a union."

Unions in the News

Rockford docs voting on unionization issue

Patient care, not money, is the primary reason doctors unionize, according to Budrys. In Rockford, Illinois, 180

U.S. Physicians Seek Collective Bargaining POWER

Story by Howard Bell

Poster by Joel Rodgers

physicians say patient care was harmed when they sold their practices to Rockford Health Systems (RHS) and became employees. RHS operates a hospital and 11 clinics in the Rockford area. RHS doctors formed the Rockford Physicians' Council, which will hold an election this spring to see if at least 51 percent of employed physicians in nonmanagerial positions want the council

to be their official collective bargaining unit. "We think two-thirds to three-fourths of doctors support us," says Douglas Kaplan, M.D., president of the Rockford Physicians' Council and an RHS ophthalmologist.

Rockford Health System asked the doctors to work with RHS administration to solve problems instead of forming a union, which RHS said would breed division and mistrust. RHS administrators organized their own group of doctors—the Physician Leadership Group—to enact some of the council's recommendations, hoping to quell interest in unionizing. They also restructured leadership and created mechanisms by which physicians

could have more say in budget decisions. Hiring a physician CEO is under consideration as well.

Not good enough, says the council. RHS beefed up physician representation on the board with physicians sympathetic to administration, states Kaplan. "Physicians in charge must be democratically elected, not hand-picked by administration."

The council filed an unfair labor practices suit against RHS, claiming the Physician Leadership Group is an illegal "management union." Furthermore, the suit asserts RHS threatened physicians with dismissal if they support council activities. In January, the National Labor Relations Board (NLRB) ruled in the council's favor. RHS, the ruling said, is guilty of two counts of violating federal labor law.

RHS denies any wrongdoing and refuses to negotiate with the council. NLRB will proceed with formal charges and a hearing. It is also requiring RHS to dissolve the Physician Leadership Group, even though the council said it would support the group if members were elected, not appointed.

"Had administration been willing to negotiate with us, we could have preserved some of the good changes they made that we all support. Now the government may undo everything."

—Douglas Kaplan, M.D., Rockford Physicians' Council

The Legal Requirements of Unionization by Gordon J. Apple, J.D.

The National Labor Relations Act (Wagner Act) of 1935 established laws governing union membership and collective bargaining and created the National Labor Relations Board (NLRB) to oversee union activity. Under the Wagner Act, employed physicians, such as those of the Allina Medical Group and Mayo Clinic, can elect to form or join a union, but independent contractors cannot because of antitrust concerns. As increasing numbers of physicians become employees rather than independent contractors, the union option becomes reality from both a practical and legal sense. Nationwide, 45.4 percent of physicians were employees of health care organizations in 1995, compared with 24.2 percent in 1983.

The NLRB rules for union representation are well defined. The process begins with union organizers, either internal or external, obtaining sufficient support (currently 20 percent) among the prospective bargaining unit members to designate a union representative. If this support is obtained, the union submits the information to the NLRB along with a request for an election. The NLRB defines a bargaining unit and provides for a secret ballot election. Before the election, a campaign is held following NLRB fair labor practices. If a majority of the prospective members appoint the union as their represen-

tative, then all members of the unit are required to join the union and be represented by it in negotiations with management.

Although some physicians might initially resist the idea of being part of a union, fearing the loss of personal independence, union membership does not mean the end of independent deals. Consider Kevin Garnett's contract with the Timberwolves in the overall context of the NBA players' union contract.

Physicians in New Jersey recently tried and failed to expand the scope of the Wagner Act by arguing they were virtual employees of large payers. An NLRB regional director rejected a union's petition to represent some 500 physicians in collective bargaining with a large HMO because the director believed the doctors retained the status of independent contractors. She rejected the argument that the HMO was a de facto employer because of its influence over workplace conditions, medical decision-making, and the fact that the marketplace had been reduced to a small number of powerful health plans—much like in Minnesota. The decision is being appealed, although the appeal is unlikely to succeed. Nevertheless, the case is an indicator of just how far some physicians are willing to push the envelope in trying to influence their negotiations with HMOs and other large payers.

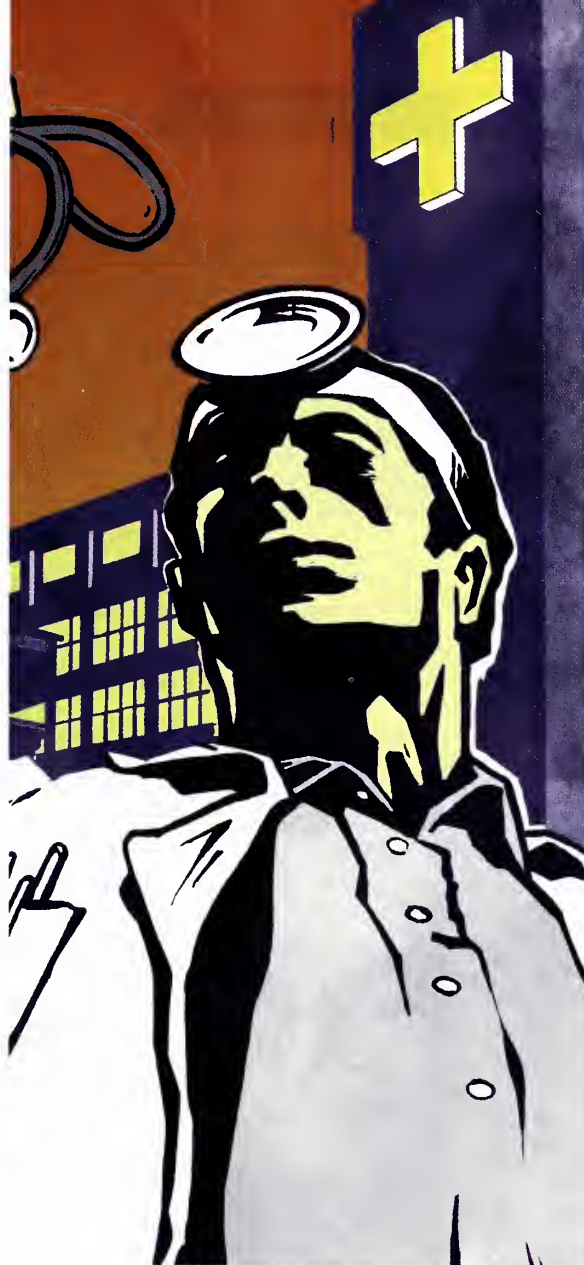
RHS's reasons for not negotiating or admitting guilt are understandable. NLRB would have required RHS to undo all actions implemented by the Leadership Group. RHS would also be required to post notices throughout its facilities declaring its violations.

In an interesting twist, RHS says it will fight efforts to unionize because unionizing would disqualify physicians from the decision-making power they seek. By law, they say, union and management must be separate, which means union doctors could not chair committees or be voting members of the board of directors.

That's partly true, says Kaplan, but it's mostly PR spin designed to discourage doctors from organizing. "Union members who chair committees cannot be voting union members. Once they step down from their chairmanships, they are once again voting members of the union," Kaplan says. "What's important is that they are on the committee representing the union viewpoint."

As the aggrieved party, the council can hold elections to unionize whenever it wants. It plans to do so in late March, according to Kaplan, who is surprised at how hard the NLRB came down on RHS. "Had administration been willing to negotiate with us, we could have preserved some of the good changes they made that we all support. Now the government may undo everything."

Meanwhile, the council issued a series of "platform papers" detailing specific concerns. Among them are "administrative decisions to pressure physicians to increase patient volume, oftentimes to unacceptable levels that could jeopardize the quality of patient care." Turn-around for lab tests and dictations are unacceptable because of excessive staff cuts. Nurses are overworked, and physicians fear losing their jobs if they complain. First on their to-do list—make Rockford Health System less of a top-down organization so nonmanagerial physicians have more say in staffing levels, purchasing deci-



sions, productivity quotas, and managed care contract negotiations. "The caregivers need to be in charge of care," says Kaplan.

Winnebago County Medical Society and the AMA are helping the council get collective bargaining rights, according to Carol O'Brien, senior attorney in the AMA's Health Law Division. O'Brien also directs AMA's new Division of Representation, established to help doctors negotiate with health plans. The AMA is subsidizing the Rockford Physicians' Council efforts by providing the services of two experienced labor attorneys.

The council has pledged not to affiliate with a large labor group or engage in strikes or other actions that harm patient care. "We encourage physicians to follow the Rockford model," says O'Brien. "Many physicians feel they'll get more clout and power by joining a large labor group, but we feel it's more professional and effective for physician unions to stay independent."

Thomas-Davis Medical Center fights to have union recognized

For doctors to bargain collectively, they must be employed in nonsupervisory positions. A physician union at Thomas-Davis Medical Center in Tucson, Arizona, represented by the Federation of Physicians and Dentists, achieved a significant legal victory when the courts determined last September that the physicians were not supervisors for the purposes of interpreting the National Labor Relations Act (for more information on this act, see the sidebar on facing page).

FPA Medical Management, the San Diego practice management firm that owns Thomas-Davis, refused to negotiate with its physicians, saying their union was illegally constituted. A district judge ruled otherwise and ordered FPA to do the following:

- Negotiate with the doctors for all terms of employment and working conditions, including compensation, benefits, hours, patient panel sizes, and staffing levels.

- Return all salaries and working conditions to those that existed in December 1996, when Thomas-Davis physicians voted 3-1 to unionize. (FPA cut salaries 25 percent to 50 percent.)

- Allow Thomas-Davis physicians who resigned (half the medical staff) to petition to get their jobs back.

- Offer jobs back to 19 physicians who resigned under certain circumstances.

- Restore the in-house specialty referral system and extend hours of operation for urgent care.

Only three physicians wanted their jobs back, according to Keith Dveirin, M.D., a Thomas-Davis pediatrician and union president. "Doctors continue to leave," says Dveirin. "FPA still declines requests to set up more negotiation sessions, even though they're under court order to negotiate."

FPA is appealing the court decision, which may take another couple of months to resolve and is unlikely to succeed, according to Jack Seddon, president of the Federation of Physicians and Dentists.

Factors Creating a Union Environment

by Gordon J. Apple, J.D.

A variety of factors motivate physicians to explore the possibility of joining or forming unions. Uneven bargaining power and omission from the decision-making process are common frustrations that warm the hearts of union organizers. Union sentiment appears to be increasing nationwide as managed care penetrates the marketplace and more and more physicians become employees of large organizations. Following are three examples of frustrations that provoke physicians to join unions.

No Voice in Negotiations

Groups of employed physicians sometimes consider the union option when confronted with indifferent employers or management. For example, if the fictional Osceola HealthSystem is considering merging with HealthSystem Goodrich and Osceola's physicians feel they are only getting lip service from senior management in the negotiation process, the physicians could form a union to gain leverage in the negotiation process.

A similar scenario recently unfolded on the East Coast when Blue Cross and Blue Shield of Massachusetts decided to sell a number of clinics. The doctors who practiced at these clinics sought input in the negotiation process with prospective buyers but apparently were rebuffed. To counter this indifference, about 70 physicians formed an independent union that was certified by the NLRB. By doing so, they forced both Blue Cross and Blue Shield and prospective buyers to address their concerns.

The FTE Phenomenon

Another factor that may lead to unionization is the FTE phenomenon. Physicians employed by large organizations become full-time equivalents in the eyes of health care administrators and executives. If an organization has 300 FTEs, administration is unlikely aware of, much less concerned about, the .4 FTE pediatrician working in Woodbury. Generally, that particular FTE only hits management's radar screen if she is a DPE (disgruntled present employee) or a soon-to-be DFE (disgruntled former employee) because she is part of the latest RIF (reduction in force). Of course, DPEs and DFEs are not viewed as a team players.

The situation can lead to a sense of alienation among physicians. If enough DPEs exist in a health care system and both the FTEs and DPEs know quite a few DFEs, you have a mix that may lead to unionization.

The Economics of Medicine

Managed care administrators often use financial incentives to discourage what they consider overutilization. Such incentives have caused some patients to doubt the sincerity of the physician-patient relationship. Employed physicians may consider unionizing when the production mandates of management disrupt or override the ethical ideals of medical practice.



"Union lawyers have the expertise to negotiate better deals for doctors without violating antitrust laws. As a third-party messenger, we present counterproposals."

—Jack Seddon, FPD

Dveirin says his group thinks affiliation with the Federation of Physicians and Dentists is well worth the \$620 annual dues. The union pays all attorneys' fees and provides access to "fantastic legal counsel."

Resident unrest surfaces on the coasts

Resident physicians have long complained of being overworked and underpaid. On the East Coast one group of residents is looking closely at unionization issues; meanwhile, a West Coast residents group may be wishing it hadn't unionized.

Residents are free to form collective bargaining units, but private teaching hospitals are not required under federal law to recognize them. The NLRB considers residents students rather than employees (although the Internal Revenue Service generally treats them as employees).

Residents at Boston Medical Center hope to change the NLRB's position. They've asked the NLRB to let them form a house staff union and to reconsider its 1976 decision that residents are students and cannot bargain collectively.

The NLRB will rule on the Boston Medical petition this spring. "Once a group has NLRB certification, employers are legally obligated to sit down and negotiate," says John Ronches, executive director of the Committee of Residents and Interns (CIR) in New York City. A win would clear the way for unionizing the country's 110,000 residents, interns, and fellows.

CIR represents about 10 percent of U.S. residents and interns (about 9,500). Most work at public hospitals and have bargaining rights under state labor laws. CIR is affiliated with the Service Employees International Union, a member union of the AFL-CIO. For members unable to bargain collectively, CIR has facilitated voluntary agreements with employers to improve resident working conditions.

At the AMA's Interim Meeting in December, leaders of the resident representation movement said they will get bargaining rights one way or another—if not through NLRB, then through a policy mediated by the Accreditation Council for Graduate Medical Education. What counts, they said at the Dallas meeting, is getting some means of organizing at the local level to solve local problems.

Residents in California are complaining of an entire-

ly different problem—and may provide a lesson for other residents seeking to unionize. A 1986 California Supreme Court decision ruled that residents are employees and can form bargaining units, and the California Association of Interns and Residents (CAIR) affiliated with Local 250 of the Service Employees International Union in 1995. *AM News* reported in January that members of CAIR are now seeking to disaffiliate from the union, claiming it has

engaged in a "hostile takeover" of the resident organization.

CAIR leaders accuse the union of taking control of the group's finances, firing staff, and making tactical decisions without consulting its members. In addition, they claim the union has not fought hard enough for resident bargaining rights with University of California hospitals; the hospitals refuse to recognize residents as a bargaining group, claiming that the 1986 Supreme Court ruling no longer applies because residency training has changed so much since the ruling.

CAIR President Elizabeth Quinn, M.D., says the union is only interested in recruiting other practicing physicians to join the union. Residents have complained that the union has used CAIR funds to create brochures for soliciting other physicians to join the union.

"Local 250 doesn't give a damn about what residents want or need," said Quinn in the *AM News* article. "They are looking beyond us."

The union begs to differ. President of Local 250, Sal Roselli, says the residents seeking to disaffiliate constitute a small group that is loyal to one disgruntled former staff member who was fired. "Anyone who tries to say we aren't doing the best we can for residents is an outright liar," Roselli told *AM News*.

Independent Docs Turn to Unions for Representation

It's unlikely independent doctors in private practice will win the right to bargain collectively any time soon. Five hundred independent physicians in New Jersey asked the NLRB for permission to do so on the grounds that HMOs give them little control over their practices, which makes them "virtual employees" (see the sidebar, page 12). The NLRB said no.

"Their argument is not persuasive enough," says AMA's O'Brien. "As long as you run your own office and



have your own managed care contracts, you're not employed by someone else." Even so, unions can still help independents gain negotiating power.

National labor unions provide independent physicians such benefits as sample contract language and comparative reimbursement rates. They collect complaints filed against managed care organizations and track how much revenue plans put back into patient care (medical loss ratios).

"All of this is useful bargaining information," says Budrys. "All of it is costly and time-consuming to get on your own."

Unions cannot offer in-

"Is it a violation to decline to participate in a capitation contract? If the Justice Department says we've done nothing illegal, other specialties around here will rush to join the union. It'll be a horror story for HMOs."

—Miami orthopedist

The Minnesota Perspective By Gordon J. Apple, J.D.

Although white coats and blue collars have not yet entered the labor scene in Minnesota, clearly the elements that have driven physicians to unionize around the country exist in Minnesota as well. While Minnesota physicians have not been leaders in the union movement, no one should question the ability of Minnesota's employed docs to become quick studies.

There are several potential places where physician unions could incubate. First, one of the large employed physician groups affiliated with a major health system could seek to work as a collective bargaining unit. Medical residents are another group that could push the union button. Residents in other parts of the country have joined unions or are discussing the possibility (see cover story text).

On the other hand, Minnesota physicians may feel a stronger bond to the ideals of their profession. Steven Miles, M.D., a faculty member of the University of Minnesota Center for Bioethics and a HealthPartners physician at Regions Hospital, is wary of physician unions. He asks for whom or what a union would advocate: for patients, the profession, a better health care system, or simply for doctors' wages, benefits, and working conditions?

"Central to the idea of a medical 'profession' is loyalty to the interests of patients. There's a tension between professing, which binds doctors to patients, and organizing, which is in the interest of doctors. A union would shift physicians away from professionalism," Miles says.

Paul Matson, M.D., chair of the Minnesota Medical Association's Board of Trustees, expresses a similar concern with unions. "One primary tool of unions is the threat of strike, but physicians consider it unethical to withhold care from patients. If you're

going to threaten to strike, you must be prepared to go through with it," says Matson, who is also an orthopedist with Orthopaedic & Fracture Clinic in Mankato.

Nonetheless, he points out that the health care marketplace in Minnesota fits the typical unionization scene. "Unions have traditionally risen when an employer has tremendous power and control. In the Twin Cities metro area, three payers cover about 80 percent of the population. There is tremendous disparity of economic power in this market." However, the physicians most affected are independent contractors, who are not allowed under federal law to collectively negotiate.

"Other methods short of unionization allow physicians to come together for contracting, such as independent practice associations and physician management organizations," says Matson.

Minnesota health plans, for their part, are taking a wait-and-see approach to physician unions. Few organizations are willing to say they are opposed to physician unions; instead, they say they have no position at this time. Nevertheless, under the calm surface, unionization seems to be a sensitive topic for some large physician employers.

Employers have reason to dislike unions, but several factors prevent them from taking a hard public stance. First, as large employers with equally large nonphysician union workforces, they know tranquility on the labor front is important. Second, physician employers know that self-insured companies and their employees might question whether they want to affiliate with a plan that has labor problems. Faced with this reality, health care networks are likely to say that if physicians join a union, they will honor that decision and negotiate in good faith. Of course, in the

dependent physicians collective action, but they can offer a collective stance, according to Gary Robinson, executive director of the Union of American Physicians and Dentists. "We turn the work-related challenges encountered by individual members into valuable lessons for the entire membership," he says.

The Federation of Physicians and Dentists (FPD) in Tallahassee is typical of what large labor unions offer independent physicians. It acts as a go-between to resolve reimbursement problems and contract issues. It interprets regulations and legislation, actively represents members in the legislature, and submits supporting briefs in court.

FPD acts as a third-party messenger for 90 percent of orthopedic surgeons in Tampa, Florida. "Union lawyers

have the expertise to negotiate better deals for doctors without violating antitrust laws," says Jack Seddon, FPD president. "As a third-party messenger, we present counterproposals. We function very conservatively to protect our members from antitrust laws."

Seddon says the FPD reviews physician contracts and HMO policy changes made without physician input. "We aren't as focused on payment issues as we are in flagging language that gives insurance companies the right to unilaterally alter agreements," says Seddon. "We make sure contracts allow doctors to file grievances beyond the internal mechanism the company offers."

The Tampa orthopedists referred to earlier declined to renew their contracts with Tampa's three biggest insurance companies. They've done so without bargain-

same breath, they are likely to question why such a move would be necessary in the first place.

Allina's vice president of medical management and policy, John Kleinman, M.D., says Allina does not have an official position regarding physician unions, and the health plan is not aware of any efforts to form one.

Before joining a union, Kleinman says, physicians should consider, "Who am I willing to have represent me, and to whom am I willing to entrust my livelihood?" Kleinman believes the most effective way for physicians to gain representation is to run for the board of directors or to work hard to get their representatives on the board.

Maureen Reed, M.D., HealthPartners' medical director for contracted care systems, says she meets regularly with physicians from the medical groups with which HealthPartners contracts. "I don't hear any discussion of physician unions—I've heard no medical leaders talk about it."

As for HealthPartners' position on unions, Reed says the health plan has always maintained that medical groups should do what they feel is in their best interest. "That's their business. Our business is to ensure that our members get good health care."

Hennepin Medical Society CEO Jack Davis says his organization has looked at physician unions or "collectivism," but the issues generating concern among HMS members—such as loss of clinical autonomy or threats to the physician-patient relationship—aren't likely to be resolved by physician unionization.

Roger Johnson, CEO of the Ramsey Medical Society (RMS), says he has seen no evidence of union activity locally. He praises Medica for holding quarterly meetings with

the heads of the Minnesota Medical Association and the Ramsey and Hennepin medical societies to discuss physician concerns. He encourages other plans to do the same.

For its part, the Minnesota Medical Association is working closely with the AMA's new Division of Representation, established to help doctors in their relationships with health plans. Together with the new AMA division, the MMA, HMS, and RMS recently offered a seminar on managed care contracting based on the AMA's managed care model medical services agreement.

"Although the MMA cannot collectively bargain for independent physicians, it can and does advocate for physicians," says Matson. "For example, when Medica announced last summer that diagnostic radiology services would be subjected to a cumbersome and time-consuming preauthorization process, many physicians were concerned about the impact this would have on their patients' ability to receive those services. The MMA was able to pull together information about this problem, take that information to Medica, and advocate for an effective resolution."



ing collectively and without violating antitrust laws—so they hope.

"Is it a violation of antitrust to say no thanks to the discounted fees an HMO presents us?" asks one of the orthopedists. "Is it a violation to decline to participate in a capitation contract? If the Justice Department says we've done nothing illegal, other specialties around here will rush to join the union. It'll be a horror story for HMOs."

Recently, an independent practice association of 130 Miami doctors asked the FPD to review their contracts and craft language that eliminated unilateral decision-making. "We helped them get reasonable reimbursement rates," says Seddon. "We can't discuss terms in groups, so each doctor got a copy of rates and decided on their own whether to accept them. We've been able to resolve 99 percent of problems in every situation."

Half of UAPD's 5,000 members, most of whom practice in California, are independent. The union recently helped some California doctors negotiate a contract that will allow them access to more patients, according to Robinson. UAPD is currently negotiating with a California HMO that decided to eliminate large numbers of specialists from its plan. They also filed suit against an IPA that terminated several contracts without giving physicians due process. They routinely represent individual physicians excluded from plans. In one case, a simple letter to the HMO outlining the physician's rights was sufficient to sway the HMO. They've helped

physicians collect money from Medicare and HMOs and to prepare for audits.

UAPD represents 1,000 physicians outside of California, a number likely to grow, according to Robinson. "We are currently meeting with doctors in Philadelphia and Detroit," he says.

The Office and Professional Employees International Union (OPEIU) is attracting independent physicians to its National Guild for Medical Providers. It has pledged to help its members win contracts with employers and fight policies that limit access to specialists. The guild is about to combat limited capitation in some U.S. Healthcare and Blue Cross and Blue Shield plans, according to John Mattiacci, podiatrist and union president.

Jay Porcaro, OPEIU director of organization, says the union encourages corporations

to use physician networks and insurance companies that have quality rather than cost reduction as their primary goal. OPEIU is currently meeting with major hospital chains to form an AFL/CIO-preferred managed care network. "Organized labor represents 54 million consumers," he says. "That gives us a lot of buying power."

Physicians in Kentucky, Florida, and Puerto Rico are considering whether to join. The National Guild for Medical Providers only accepts members of state professional societies, according to Mattiacci. "We do not want to be a threat to organized medicine," he says. "We want to work with them."

Organized Medicine Steps Up to the Plate

The AMA's Division of Representation has scored significant victories for independent physicians without union involvement, according to attorney O'Brien. In a strongly worded letter to Physicians Health Network (PHN) of Evansville, Indiana, the AMA criticized PHN's decision to no longer reimburse the cost of having assistant surgeons present for cesarean sections and laparoscopic vaginal hysterectomies. "Determination regarding the need to have a physician surgical assistant present at a surgical procedure is a medical decision, not a coverage decision," says the AMA letter. PHN changed its tune and has continued to authorize physician surgical assistants, according to O'Brien.

In a letter to Aetna Inc.'s U.S. Healthcare Division, the AMA criticized contract language that affects physicians in several states. Clauses give the insurance company power to override patient care decisions without opportunity for physician appeal. Aetna controls patient care but makes physicians liable for the outcome of that care. Aetna quickly changed some contract language in response to the letter and has stated publicly that it will modify some contract provisions, according to O'Brien.

At the AMA's Interim Meeting in December, the House of Delegates drafted a model contract physicians can use as a guide when negotiating. "The contract balances legitimate business needs of a plan with the ethical and legal needs of a physician," says O'Brien. (See "The Minnesota Perspective," page 16, for information on MMA activities.)

Unionizing has given many physicians control over their working lives—some say it beats fighting the system alone. Whether unions will be the antidote to physician frustration is far from certain. The nutrient broth of frustration is still coalescing.

MM

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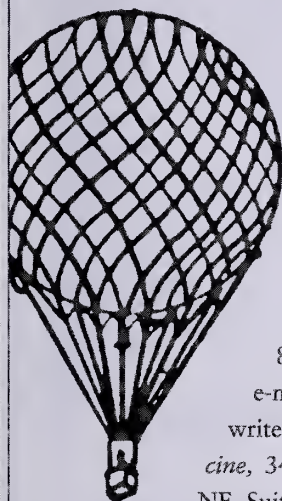
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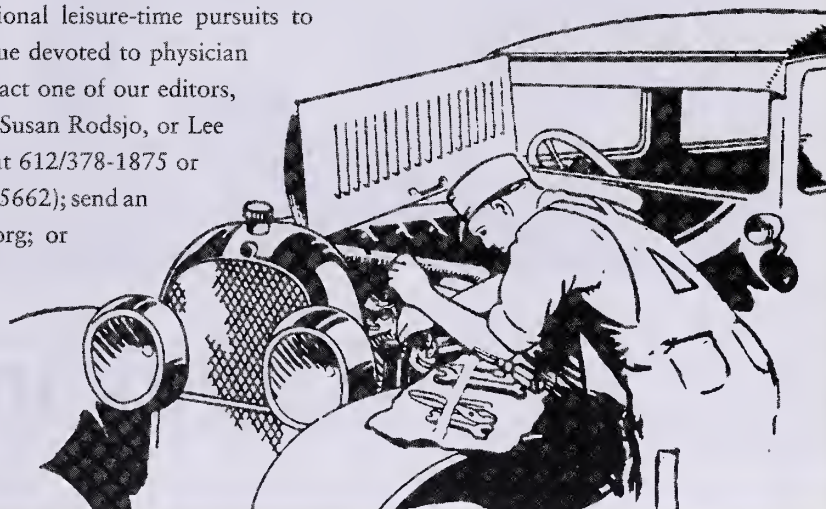
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The Hospitalist Trend

BY LENORE FRANZEN



ILLUSTRATION BY RUSS MCMULLIN

A Work in Progress

Hospitalists seem to defy classification. While not new to Minnesota, the use of in-hospital physicians still leans toward the experimental. Five years ago, the first hospitalist was hired in Minnesota, and since then, other physicians have entered into hospitalist arrangements. Yet nearly every model differs, in semantics and sophistication, suited to a specific situation.

A Variety Pack

In the strictest sense, *hospitalist* refers to a physician who assumes complete in-hospital care for a patient. Although the patient may have a different primary care physician, while the patient is hospitalized, the hospitalist serves as the primary physician. Janet Grayson, M.D., is a hospitalist for Park Nicollet Clinic, practicing full time with three other in-hospital physicians at Methodist Hospital. "I have patients who consider me their 'hospital doctor,'" she says.

Grayson says that some patients found the adjustment difficult at first, particularly older patients who had seen the same physician for 30 years. "It's fortunate when those doctors stay involved. ... You have to be better for and to [patients] than their doctor because you're there all the time," she insists.

When the patient is released, care transfers back to the personal physician. "In this kind of model, you have to work exceedingly hard at communicating," Grayson says. She identifies voice mail as an efficient, timely way to relay patient information to the primary care physician. E-mail also makes communicating easier.

Bob Miner, M.D., the state's first hospitalist, fits a very different model. Part of a four-physician group at Abbott Northwestern Hospital, Miner was hired in 1993 to start an inpatient service that would provide care for a particular patient population: outstate referrals, indigents, and unassigned emergency room admittees. "The need arose because a few physician groups didn't want to do inpatient medicine," he says. "They didn't want to handle rotations, emergency room patients, indigents, and no-shows. Abbott also wanted to accept more outstate transfers."

This arrangement suits Miner, the hospital, and the patients he serves. Attractive to him—and perhaps surprising to others—is the balance his practice affords. "We're able to do a lot of things," he says. "We see patients about 50 to 60 percent of the time. We teach quarter time, have administrative duties, and participate in scholarly research." As a result, Miner has avoided the burnout often associated with hospitalists who only see patients.

Jamie Peters, M.D., does *not* favor a strict division of labor between clinic and hospital physicians. He introduced a joint rounding model in 1985 while at Park Nicollet. "We all had one or two patients in the hospital," he explains. "We were running back and forth and didn't have time to manage their care. In this model, each physician spends one day a week in the hospital."

When Peters moved to Northwest Family Physicians in 1987, he applied the model there. He believes that his and his colleagues' hospital skills have remained at a higher level. "These skills help us stay current on specific areas of medical problems and common entities we admit patients for," he says, citing cardiac and respiratory diseases as examples. "Physicians need to be able to function within a hospital environment." This might mean being familiar with a hospital's systems, knowing how to access information, working directly with specialists on a regular basis, and ordering care.

In addition to his clinic duties and weekly rounds, Peters directs the family practice residency program at Smiley's Clinic. "We're careful to train our residents comprehensively in hospital skills, emergency medicine, and acute care," he says. "The hospital skill level of physicians completing the major family practice medical programs in this area is very high," he adds.

Grayson, Miner, and Peters represent a variety pack of in-hospital care providers. Each has found a satisfying situation. Grayson, who started in family practice, discovered her preference for hospital work after her youngest child went through chemotherapy for a tumor. "I was grumpy with the 'worried suburbanites,' but OK with sick people," she says.

Miner has always felt more at home in a hospital

A survey of
Minnesota's
hospitalist landscape reveals a
variety of
arrangements
for providing
inpatient care.

setting. "Most of my training was in hospital-based medicine," he explains. "The variety of patients I see and that are referred in provide a lot of interesting disease processes and illnesses to treat."

Peters likes how outpatient and inpatient care complement each other. "Being in the hospital for even a day a week has a natural effect on my ability to care for patients in the clinic. It helps me provide better post-hospital care."

Do All Roads Lead to Hospitalists?

While some physicians have chosen the hospitalist route, others fear they may lose hospital privileges entirely if only full-time hospitalists are allowed to provide care for hospitalized patients. Family physicians are most directly affected. They worry that patients get caught in the middle and quality of care suffers.

"When you have two sets of physicians, they may look at patients differently," says Ken Kephart, program director of the University of Minnesota/HealthSystem Minnesota family practice residency program and immediate past president of the Minnesota Academy of Family Physicians (MAFP). "For example, an elderly man with multiple medical problems and recurring hospitalizations may not be doing well in a number of areas. The primary care physician is trying to look at that patient and find an effective plan to maintain his health at the highest level."

Kephart says he worries about problems with communication after a patient is discharged from the hospital, such as compliance with medications.

Continuity of care is another concern. Tim Komoto, M.D., current MAFP president, notes, "From a family practice perspective, we value continuity of care, balanced with the realities of efficiency and clinic flow. In our family practice group of 12, three physicians do hospital rounds one week at a time at three different hospitals." The shared rounding concept, like the system Jamie Peters developed, allows physicians more control of the parameters. When they aren't able to see their own patients, someone within the group can. "The key is communication between the partners," says Komoto.

Speaking for MAFP, he adds, "The academy's concerns are around privileges and relinquishing patient care. Family physicians are trained to care for inpatients. With a hospitalist model, it's like being told you can't do that anymore." At the MAFP's annual meeting in April, Neil H. Brooks, M.D., American Academy of Family Physicians president, will speak on the hospitalist trend and its implications.

At a September 1997 meeting, AAFP delegates

agreed to form a task force to study the impact of hospitalists on family practitioners and patients. Specifically, the group will look at continuity of care; capitation rates and physician reimbursement; quality of care; the changing nature of inpatient care; loss of contact with other physicians in an inpatient setting;



the impact on perceived status of family physicians; coupling inpatient privileges with managed care payment for services and procedures; regaining privileges after voluntary or mandatory relinquishment; and adequacy of family practice residency models for training physicians to work in a hospital setting.

Origins and Rationale

Long used in Europe and Canada, hospitalist programs have gradually taken hold in the United States, particularly on the coasts. In 1985, University of California–San Francisco physician Robert Wachter, M.D., coined the term *hospitalist* in an article he wrote for *The New England Journal of Medicine*. Since then, hospitalist models have slowly spread throughout the country.

In January 1997, John Nelson, M.D., a practitioner in Gainesville, Florida, cofounded the National Association of Inhospital Physicians (NAIP). “Our organization is a way for members to share ideas and interact with other physicians doing inpatient care,” he says. He estimates that about 2,000 hospitalists practice in the United States. NAIP will host its first-ever annual meeting this April in San Diego.

While some physicians argue that cost is driving the hospitalist trend, others believe it has more to do with improving the quality of inpatient medicine and making physicians’ work schedules more predictable, their lives less hectic. George Morrison, M.D., a family physician at the Woodlake Clinic, made regular hospital visits until three and a half years ago, when Allina began an inpatient service at Abbott. Morrison chose to use the service, though not exclusively, to gain control over his schedule. “This arrangement allows me to control my call schedule and my clinic time,” says Morrison. “I’m not caught in the middle of a catastrophe.”

He says he doesn’t know of any patients who plan to find another doctor if he doesn’t handle their hospital care. “The hospital stay should move more rapidly with a [hospital-based] physician there,” he notes. He will continue to see his hospitalized patients who are anxious about their hospital stay, however.

Variations on a Theme

Minnesota has been in the enviable position of watching and learning from hospitalist experiments in other states and countries. In addition to a few established models, others are taking shape. All are found in an urban environment, where the

demand and need are greatest.

“We have a couple of models that have been in place about a year,” says Gordon Alexander, M.D., senior vice president and medical director of Fairview Health Services. At some clinics, he explains, physicians see hospitalized patients on a rotational basis. Fairview–Ridges subcontracts with doctors for inpatient care, and Fairview–University Medical Center uses full-time hospitalists. The university coordinates a teaching service with residents, who perform essentially as hospitalists.

HealthPartners introduced a model for its two regional hospitals, Methodist and Regions, in January 1998. It draws on several established national programs. “Our hospital care specialists are the lead professionals for the hospital care team,” says Stanley Russin, M.D., head of internal medicine and director of adult hospital services for HealthPartners. “They oversee the care coordination of hospital care, provide support to rounders, and help them navigate in the complex hospital environment.”

Two hospitalists share one position. They alternate working seven 10-hour days and having a week off. “Our hospitalists spend about 20 percent of their time as care team leaders and about 70 percent of their time with patients who are the sickest and have the most complex medical problems,” he adds. “We didn’t reduce the number of rounders; we simply enhanced the number of resources for providing inpatient care.”

The hospitalist trend in Minnesota is a theme with many variations. Even practicing hospitalists and systems with hospitalist programs hesitate to predict which model will last and how inpatient services will affect family physicians and quality of care. Best to proceed with caution, most health care providers say, acknowledging that today’s model, like other aspects of health care, is a work in progress. MM

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Character Healing: A Fresh Look at Psychodynamic Psychotherapy

Aviel Goodman, M.D.

ABSTRACT

Caught between the successes of modern psychopharmacology, the requests of suffering patients for quick relief, and the shortsightedness of many third-party payers, psychodynamic psychotherapy might seem to be on the ropes. It is, however, thriving and providing crucial help to many individuals for whom medication and brief counseling are insufficient. Meanwhile, many more who could benefit from psychotherapy do not have an opportunity to do so. Although psychodynamic psychotherapy originated and developed within a medical framework, it has minimal visibility on the current medical scene, and many physicians have been provided with little meaningful information about it. This article is intended to give physicians a general idea of what psychodynamic psychotherapy is and how it works.

Many individuals who could benefit from psychodynamic psychotherapy do not receive it. I believe that one reason psychotherapy is underutilized is that psychotherapists have not done an adequate job of communicating to physicians and the general public about what psychotherapy is and how it works. In this article, I offer a general description of psychotherapy. This description is not a scholarly review or a definitive synthesis, but a way of understanding psychodynamic therapy that I have found useful.

DEFINITIONS AND GOALS

Psychotherapy is a form of treatment for mental, emotional, behavioral, and interpersonal problems. While psychotherapy is a biological treatment,¹⁻⁵ it is distinguished from other health care treatments by its reliance on dialogue between clinician and patient. Psychodynamic psychotherapy helps people to know themselves and to grow—that is, to discover and develop psychological processes that generally have remained outside their awareness. The primary functions of psychodynamic treatment are 1) to enhance individuals' ability to regulate their emotional states and their sense of self, and 2) to foster their capacity for meaningful interpersonal connections. The fabric of psychotherapy is woven from three strands: understanding, integration, and internalization.

UNDERSTANDING

Understanding in psychodynamic psychotherapy focuses on fostering an appreciation that our subjective experiences and our behavior have identifiable relationships with meaningful mental or psychological processes. Even when these processes are

not accessible to our conscious awareness, they still can be understood. Such an appreciation provides a framework for working productively with the psychotherapeutic process. Let us consider what such a framework might look like in treating two different conditions—disorders of painful affect and addictive disorders.

Affect is a psychiatric term that designates a complex emotional process with subjective, physiological, behavioral, and interpersonal aspects. Affect is similar in meaning to *emotional state*, but not to *feeling*, which designates only the subjectively experienced aspect of an affect.

Many individuals suffer from painful affects, usually anxious or depressive affects. When beset by painful affects, a person's natural tendency is to try to get rid of them. The view that painful affects are an enemy that must be vanquished or subdued fails to take into account that they might serve an important function. The human organism is a complex, elegant, highly developed, and sensitive system shaped by millennia of evolution. That something as prevalent as anxious or depressive affects would occur by chance in such a highly developed system is improbable. More likely, the human capacity for anxious and depressive affects developed and persisted because it had significant adaptive value.

What could be the adaptive value of painful affects? Affects are signals.⁶ As outward interpersonal signals, they communicate information about our emotional states. Their inner or subjective expressions are signals that we send to ourselves—signals of something that an automatic process within us interprets as

psychologically important. Getting rid of an important signal because it makes us uncomfortable is like shutting off a fire alarm because it makes an ugly sound. We do better to find the fire, address it directly, determine how it started, and then take steps to decrease the likelihood of another fire. If we consider the fire alarm as a metaphor for painful affects, then the referent for the complex metaphor of finding the fire, addressing it, and so forth would be psychodynamic psychotherapy. Psychotherapy enables us to discover the relationships between painful affects and the complexes of needs, wishes, fears, inner conflicts, core beliefs, and self-protective processes that have been triggered by current events.

Let us turn to a framework for working with addictive disorders.⁷⁻⁹ An addictive disorder is a condition in which a behavior that can function both to produce pleasure and to relieve painful affects is employed in a pattern characterized by two key features: 1) recurrent failure to control the behavior, and 2) continuation of the behavior despite significant harmful consequences. Addictive disorders originate in an impairment of the built-in system that regulates a person's affects and sense of self. Individuals whose self-regulatory systems are impaired are abnormally vulnerable to being overwhelmed by intense emotional states and loss of self-coherence. To avoid being overwhelmed, some of these individuals develop fantasies—often outside their awareness—that the potential for regulating their affects and sense of self resides in something outside themselves over which they believe they have control, such as food, a mood-altering drug, or a sexual partner. Individuals whose fantasies of this type lead them to engage in some form of pleasure-producing behavior in a pattern characterized by recurrent loss of control and by continuation of the behavior despite significant harmful consequences can then be characterized as suffering from an addictive disorder.

The psychotherapeutic approach to an addictive disorder begins with the recognition that an urge to engage in symptomatic behavior is not

simply an evil force that must be either resisted or submitted to, but an indication that the individual's coping system is trying to ward off a disruptive emotional state that is not being effectively managed. An urge to engage in the symptomatic behavior is thus a signal of affects that need to be managed in a healthier, more adaptive manner. This approach shifts the therapeutic focus from behavior to affects: What affects are emerging? What events triggered them? What core beliefs, inner conflicts, and personal history are involved? What alternative responses would be more healthy—that is, less self-damaging and ultimately more gratifying? The therapeutic task is to discover the painful affects underlying the addictive urges, and then to discern the psychologically significant meanings toward which the affects point.

These frameworks guide the therapist's initial approach to a psychotherapeutic situation and constitute an important aspect of the understanding component of psychotherapy. Typically, patients are provided with some elementary understanding of the conditions from which they suffer, and of how psychotherapy works. The therapist offers this information either in a brief "mini-course" at the beginning of treatment, or gradually during the course of the therapeutic dialogue. The understanding that results enables patients to develop more effective and productive relationships with their painful affects and addictive urges; it also helps them develop the capacity to observe their own emotional and psychological processes.

INTEGRATION

Many individuals suffer from deficits in personality integration. A central component of psychotherapeutic treatment is promoting patients' personality integration by bringing together under the light of consciousness the "dis-integrated" aspects of their mental functions.

Automatically, without conscious intent or awareness, we engage in a variety of mental processes that protect us from emotional trauma. Most of these self-protective processes are

ways of keeping out of our awareness material that we unconsciously imagine would be overwhelmingly painful or dangerous if we were to become aware of it. This material can include affects, needs, wishes, fears, inner conflicts, core beliefs, memories, and fantasies. We usually develop these self-protective processes early in our lives, and we learn to rely on them at a time when we are small and weak, when our options for dealing with external and internal realities are limited. While these processes may have enabled us to survive psychologically in circumstances that otherwise might have destroyed us, they also entailed some costs. Since these processes operated outside our awareness, they were not easily modified or dispensed with when other, more adaptive options became available. Moreover, when we segregate segments of our experience, severing their connections with our central body of experience, we are also segregating and isolating segments of our self. This disintegration of self involves a variety of corollaries that are beyond the scope of this article. Suffice it to say that such disintegration is not conducive to optimal mental health.

The cornerstone of integration in psychotherapy is fostering patients' awareness of their affects, needs, wishes, fears, inner conflicts, core beliefs, and automatic ways of protecting themselves from emotional pain, particularly as these processes arise in the context of interpersonal relationships. As aspects of psychic function that had been hidden from consciousness come into view, they can be integrated into the healthy, adaptive dimension of the personality system.

The closer to the here-and-now that a subject being addressed in psychotherapy is, the more emotionally "hot" or salient it is, and the more likely is work on that subject to lead to improved integration and self-regulation. Particularly important to track are patients' responses to what they experience as injuries to their sense of self or their sense of connection with a significant person. In psychotherapy, the most here-and-now relationship issues are those that concern the patient's relationship with the therapist. Hence, these issues are

the most productive ones to address.

Early in life, we develop our basic inner models for how we perceive, experience, and respond to significant others, and for how we perceive and experience ourselves in relationships with others. Typically, these models emerge from our childhood interactions with caregivers, especially our primary caregivers. More than just cognitive structures or mental representations, the models are also functional predispositions—enduring tendencies to perceive, experience, and respond in characteristic ways, which are activated automatically in relationships. Each time we form a new relationship, we do not have to learn from scratch how to perceive, experience, and respond to others, because our basic inner models guide us. They are, therefore, very adaptive—but they can be maladaptive if they are out of sync with our present-day relationships. Much of our psychological pain derives directly or indirectly from aspects of our inner models that were adaptive in childhood but do not fit our current world.

In the course of psychotherapeutic treatment, a significant relationship develops between the patient and the therapist. The patient's inner models for perceiving, experiencing, and responding to significant others become activated, and the psychological factors that influence the patient's other significant relationships begin to affect how the patient perceives, experiences, and acts toward the therapist. In this sense, the therapeutic relationship resembles other significant relationships in the patient's life. It differs, however, in a crucial respect. Rather than reacting behaviorally to the content of the patient's verbalizations and actions, the therapist provides a safe environment in which the patient and therapist together can explore the meaning of the patient's responses. This collaborative exploration expands patients' awareness of their mental processes and how these processes relate to their personal history and current difficulties. As patients' awareness expands, they find opportunities to challenge and amend their maladaptive core beliefs, to resolve their inner conflicts, to get their needs met, to

manage their affects, and to take better care of themselves. Bringing together in consciousness the disintegrated aspects of a person's psychic processes gradually heals the personality and enables it to function as an integrated whole. The result is more conscious choice, more flexibility, and more freedom.

INTERNALIZATION

Earlier, I mentioned the built-in system that regulates one's affects and sense of self. This self-regulation system can be understood to consist of three primary functions: affect regulation, self-care, and self-governance. Affect regulation includes self-soothing, self-enlivening, keeping emotional states in balance, and tolerating emotions without being overwhelmed. Self-care includes self-protection (the ability to recognize and protect oneself from danger) and self-nurturing (the ability to identify and take care of one's needs). Self-governance includes values, standards, self-evaluation, self-esteem, self-punishment, and a stable and cohesive sense of self.

The self-regulation system develops through *internalization*. Internalization is a process whereby regulatory functions that had been provided by the child's caregiver gradually become integrated into the child's autonomous functional system through interactions between the maturing child and the responsive caregiver. The capacity for internalization is greatest during early childhood, but it continues throughout life. The function of internalization in psychotherapy derives from its role in the development of self-regulation.

Psychotherapy helps heal impaired self-regulation by providing opportunities for the patient to internalize self-regulatory functions that were not adequately internalized during childhood. Affect regulation functions can develop through internalization of 1) the therapist's ability to tolerate the patient's affects without suppressing them, withdrawing, acting out, or being overwhelmed; 2) the therapist's soothing and enlivening functions; and 3) the therapist's treatment of affects as indications of internal states that deserve attention. A

patient can develop self-care functions through internalization of the therapist's nurturing and protective role, as well as his or her message that the patient is worth taking care of. A patient can develop healthy self-governance functions by internalizing the therapist's integrity, respectfulness, nonjudgmental acceptance, and general stabilizing function.

Psychotherapy is not the only context in which self-regulatory functions can be internalized. Internalization can occur in any significant relationship, and also in groups. What distinguishes psychotherapy is 1) the depth of the relationship; 2) the therapeutic frame of a dyadic relationship with a figure who combines caregiving and authority; 3) the therapist's ability to facilitate the patient's personality integration and thus to minimize the extent to which the patient's projections (i.e., attributions to the therapist of affects, wishes, fears, or beliefs that belong to the patient) distort the internalization process; and 4) the therapist's level of psychological and emotional health.

INDICATIONS

Psychodynamic psychotherapy is not a panacea. Some conditions respond to it better than others do. Significantly, the distinctions between what does or does not respond well do not always correspond to standard diagnostic distinctions. The essential point is that psychodynamic psychotherapy typically treats character pathology, whatever the patient's disorder.

Character can be defined as enduring patterns of psychological and emotional processes (conscious or unconscious) that shape our inner experience and our behavior. Pathology is trickier to define, since its definition involves values. I am inclined to borrow from the DSM-III-R definition of personality disorder: personality traits constitute a personality disorder when they are "inflexible and maladaptive and cause either significant functional impairment or subjective distress."¹⁰ Accordingly, I define character pathology as enduring patterns of psychological and emotional processes that shape inner experience or behavior that is



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relatively inflexible and maladaptive (where "maladaptive" means causing significant functional impairment or subjective distress).

We recognize, of course, that personality disorder is not a synonym for character pathology. A personality disorder is the functional manifestation of character pathology, much as a word processing application is the functional manifestation of the algorithms in its program. Character pathology constitutes the emotional and psychological conditions that manifest as maladaptive personality traits. Character pathology can range from severe, as in borderline and antisocial personality disorders, to mild, as in neurotic and normal individuals. It can be associated with any type of psychiatric disorder.

Not only do some conditions respond better than others to psychodynamic psychotherapy, but some individuals respond better than others do. People who experience some distress about their symptoms, who are motivated to make changes in themselves, and who are curious about the origins of their difficulties are likely to do better than those who lack such qualities. Individuals who are psychotic, cognitively disabled, true antisocial personalities, or otherwise impaired in their capacity to form human relationships are generally not suitable candidates for psychodynamic psychotherapy. These statements, however, are only generalizations. Some bright, motivated individuals benefit little from psychotherapy because they are virtually unable to form a relationship. And some psychotic individuals who are able to make connections with their therapists can benefit considerably.

Meanwhile, therapists also differ in their capacity to form relationships and work effectively with different individuals. Some therapists, for example, are unusually gifted in their ability to form meaningful connections with antisocial individuals. An antisocial person is most likely to benefit from psychotherapy if he or she consults such a therapist. How much a patient benefits from psychotherapy thus depends not only on the personal characteristics of the patient but also on personal character-

istics of the therapist and on the relationship that develops between patient and therapist. Consequently, a therapist's assessment of an individual's suitability for psychodynamic psychotherapy includes an evaluation of how well that person "fits" with that particular therapist. Similarly, when a person looks for a psychotherapist, professional credentials, educational background, and recommendations from trusted friends are helpful, but none can substitute for a direct assessment of one's personal fit with that therapist. The occupants of both chairs in the psychotherapy office do well to remember that psychodynamic psychotherapy is not simply a therapeutic method that employs a relationship as its means; it is a relationship that serves therapeutic ends.

MM

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Controlling cost inflation is the major health care concern of our time. Whatever the future holds for the organization of medical care, our ability to control costs, in addition to achieving universal coverage, will be of prime concern.

The public seems to assume that medical science will continue to progress and that technologic advances will guarantee excellent health care. Although medicine has indeed made impressive strides, scientific progress does not always translate into better care and improved patient outcomes. What is certain is that advancing technology results in higher health care costs.

Much of what is considered inflation of health care costs is not true inflation; the increased expenses derive from new services. Health care is not akin to a gallon of gasoline or a quart of milk; the services change constantly, making cost comparisons difficult or misleading. Health care would be less expensive if we didn't have sophisticated imaging techniques, a variety of endoscopies, complex vascular interventions, chemotherapy, radiation therapy, and other technologies. But is a return to horse-and-buggy medicine acceptable or desirable? Would the profession or the public accept less modern care to achieve cost control? I doubt it.

Modern technology improves diagnosis and therapy. Although advanced therapies are sometimes used when simpler clinical approaches would suffice, controlling these excesses is difficult. If you are a carpenter and you have a hammer in your hand, much of the world looks like a nail. The proliferation of subspecialty practice has created many medical "carpenters" trained to perform a vast array of expensive procedures.

Medical care decisions should be based on demonstrated means of improving patient outcomes at the least cost, both in morbidity and dollars. By making decisions based on facts, physicians can help keep costs from escalating. One of the most important steps is to avoid practices or treatments of unproven value. In the following examples, medical practices that were widely embraced were later proven to be of no value in improving patient outcomes.

LACK OF VALID CLINICAL TRIALS

In the past few decades, a wide range of medical "breakthroughs" have been introduced with great fanfare and media hype—"miracle drugs," a "cure for cancer" just around the corner, the gamut of coronary interventions. The evening news implies that science is on the verge of wiping out disease and eradicating death. Unfortunately, despite intensive care units, chemotherapy, coronary angioplasty, and bypass surgery, no one gets out of this world alive. Improvements in life expectancy and quality of life in the aged are modest.

Complex and expensive technologies are often introduced without a demonstrated improvement in patient outcomes. New procedures and therapies are put into widespread practice, with enthusiastic acclaim from physicians and the public. Over time, controlled clinical trials show that the new technology does not improve outcomes—it is, in fact, no better than existing and less expensive care. Unfortunately, before the studies are done, thousands of patients are subjected to the new technology, with attendant morbidity, risk, expense, and disappointment.

The number of medical "advances" subsequently proven worthless is embarrassing. In the 1950s, the pericardium was abraded to enhance coronary artery perfusion. In Minnesota and other states, peptic ulcers were treated by gastric freezing—every small town had its freezing machine until significant morbidity and mortality were documented. Cervical glomectomy (resection of one or both carotid bodies) is a striking example of an unproven therapy used for asthma in the 1950s and '60s.¹ After several years and thousands of cases, controlled studies demonstrated that the operation did not alleviate patients' symptoms, dyspnea, or need for asthma medications.^{2,3}

Until the widespread use of clinical trials in coronary intervention beginning 15 to 20 years ago, a variety of unproven technologies were introduced to treat coronary heart disease. Aside from pericardial abrasion, perhaps the most ludicrous procedure was internal mam-

mary artery ligation.⁴ Ligating the internal mammary artery was supposed to divert blood to the coronaries. This relatively simple operation had low morbidity and, of course, it "cured" or "improved" up to 95 percent of patients. After several years, a sham operation—a chest skin incision that didn't touch the mammary arteries—was shown to produce equally impressive clinical results. Why didn't someone do the sham operation earlier, before thousands of artery ligations had been done? Many of the surgeons involved were unwilling to abandon the operation, in which they had developed an almost religious faith. Some surgeons hid behind the screen of medical ethics, saying they could not deprive their patients of this wonderful cure for coronary disease. The possibility that the procedure was of no value—or worse, that it was potentially harmful—was never considered.

Modern obstetric practice is replete with procedures that have not been supported by appropriate studies. Perhaps the best known of these is electronic fetal monitoring during labor, which is supposed to detect fetal distress early enough to save an infant who might otherwise die. This widely practiced procedure, introduced in the 1970s, was subsequently shown not to improve fetal outcomes.^{5,6} However, it remains an almost inviolate part of OB practice. Hospitals and obstetricians are too fearful of lawyers to discontinue fetal monitoring, even though it does not enhance obstetric care.

THE PARALLEL ROADS OF KNOWLEDGE AND PRACTICE

Medical knowledge and medical practice travel on two parallel roads, often with little connection. It takes years to translate into clinical practice what has been learned from controlled clinical trials and academic research.

When William Stewart Halsted championed radical mastectomy at the turn of the century, his stature ensured that the operation would become the standard of care for 70 years. With some notable exceptions, a surgeon who turned to any other procedure for breast cancer was criticized. Although several investigators around the world demonstrated that less invasive procedures were equally effective in controlling cancer, surgeons adhered to radical mastectomy. Not until 20 years ago, when a portion of the National Surgical Adjuvant Breast Project⁷ was completed, did surgeons switch to a less mutilating operation.

Another example was the widespread use of stilbestrol in threatened spontaneous abortion. As long as 20 years after physicians knew that stilbestrol therapy was ineffectual in preserving a pregnancy, clinicians were still prescribing it in cases of threatened abortion. This therapy was not only ineffectual, but it created a new disease in young women: clear cell carcinoma of the cervix and vagina.⁸

Why were these treatment improvements not put into practice earlier? Human nature resists change, and physicians are no different from any other group in society. It is comfortable to do things as we always have, to tread the path of least resistance. Physicians have been swayed by self-interest, the weighty opinions of influential researchers, and anecdotal evidence. The nonmedical world—government, patients, other interested parties—apparently does not even recognize medical missteps, or doesn't see the importance of correcting the problems. It is our responsibility to educate ourselves and society. We can and should make better decisions, not only to save money, but also to enhance the quality of health care.

MM

Seymour Handler is a pathologist at North Memorial Medical Center in Minneapolis.

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implies that science is
on the verge of wiping
out disease and eradi-
cating death. Unfortu-
nately, despite intensive
care units, chemo-
therapy, coronary
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of this world alive.”

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DR. JASPERS ELECTED AMA ALTERNATE DELEGATE

The Minnesota Medical Association Board of Trustees at its February 7 meeting elected Anthony C. Jaspers, M.D., as an alternate delegate to the American Medical Association.

Jaspers replaces Theodore Fritsche, M.D., who resigned as AMA alternate delegate in September due to scheduling conflicts. In order to accept the alternate delegate post, Jaspers must resign as MMA vice president.

Nominations for the vice presidency are open until the April 4 Board of Trustees meeting, at which time Jaspers will officially resign and a new vice president will be elected. To nominate an MMA member for this post, contact Karen Tourdot at 612/378-1875 or 800/DIAL MMA (800/342-5662).

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MODEL BILLING COMPLIANCE PLAN AVAILABLE

The Office of the Inspector General of the U.S. Department of Health and Human Services has created a model compliance plan to help hospitals comply with Medicare and Medicaid billing rules.

For more information, call Patricia Franklin, MMA director of legal affairs, at 612/378-1875 or 800/DIAL MMA (800/342-5662).

The model compliance plan is posted on the Internet at the following Web address:
www.dhhs.gov/progorg/oig/

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Blocks Bill to Triple Statute of Limitations

The Minnesota Medical Association has succeeded in slowing legislation that would triple the length of the medical malpractice statute of limitations.

The current statute is two years after treatment ends. The proposed legislation, H.F. 1151-Van Dellen/S.F. 1384-Limmer, would change the statute to two years after *discovery* of alleged harm but no more than six years from the last treatment in three types of cases: 1) transmission of a communicable disease; 2) in the House version, misdiagnosis of malignancy; in the Senate version, misdiagnosis of cancer, leukemia, and lymphoma; and 3) a foreign object left in the body.

As *The Monitor* went to press, the Senate bill was in the Rules Committee awaiting a decision on whether it met the committee deadline, and the House bill was before the Health and Human Services Finance Division, chaired by Rep. Lee Greenfield, DFL-Minneapolis. Testifying for the third time against this bill, the MMA raised serious concerns among members of the Finance Division about the impact this bill might have on the health care market in Minnesota and on access to care in rural Minnesota.

Dr. Whitten: Bill Is Too Broad

On behalf of the MMA, Benjamin Whitten, M.D., a Minneapolis internist and member of the MMA Board of Trustees, told lawmakers that "communicable disease" was an "extraordinarily broad category" that includes Lyme disease, hepatitis, HIV, bronchitis, the flu, and many other

See pages 35 and 36 for more coverage of state legislation.

illnesses. For a patient with a serious illness, simply catching the flu could prove fatal.

"Should I now test all my patients at each visit to establish whether they are ill in order to demonstrate later that they did not catch it from me?" Whitten asked.

Patricia Franklin, MMA director of legal affairs, said the bill would change "in isolation, and without benefit of study...one aspect of the health care liability system in such a dramatic fashion that we believe the ultimate effect will be to increase overall costs to the system." Other states with longer statutes of limitations have measures such as caps on lawyers' contingency fees to counteract the effect of higher malpractice premiums and possible defensive medicine.

Task Force Proposed

Rep. Greenfield offered an amendment to convene a task force to study comprehensive medical malpractice issues that would include not only the statute of limitations but also limits on damage awards, limits on attorney fees, and the use of pretrial certification panels.

The group would address the impact any changes might have on overall health care costs, the rights of individuals to have recourse to justice in the courts, and access to health care providers, especially in rural

Malpractice continued on page 35



Viewpoint

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Paul C. Matson, M.D., Chair
MMA Board of Trustees

MMA Fights Efforts to Triple Statute of Limitations

The MMA may have defeated attempts to triple the professional liability statute of limitations. Currently, Minnesota has a statute that works: it keeps health care costs down while allowing legitimate claims to come to trial. The statute of limitations is two years after treatment ends.

H.F. 1151-VanDellen/S.F. 1384-Limmer seeks to change the statute to two years after discovery of alleged harm but no more than six years from the last treatment in three types of cases: 1) transmission of a communicable disease; 2) in the House version, misdiagnosis of malignancy; in the Senate version, misdiagnosis of cancer, leukemia, and lymphoma; and 3) a foreign object left in the body. The bill did not meet committee deadlines and appears dead, although amendments could still be offered on the floor of the House and Senate.

The MMA argues forcefully that making radical changes in the statute of limitations without enacting comprehensive tort reform could send Minnesota's professional liability premiums soaring and increase overall health care costs.

This legislation originally would have applied to transmission of HIV from a health care provider to a patient, but the House and Senate judiciary committees amended the bill to apply to transmission of *any*

communicable disease. This broad language summons up a trial lawyer's dream—and a nightmare of litigation for everyone else. Physicians who treat infectious diseases such as AIDS, Hepatitis B, and tuberculosis could face a host of unfounded malpractice charges.

The inevitable rise in malpractice premiums would increase physicians' costs of treating patients. We believe this could eventually lead to higher health insurance premiums for our patients. As health insurance becomes more expensive, the number of uninsured will rise. Some experts predict a 1 percent increase in health care costs could result in 16,000 more uninsured Minnesotans.

The MMA fought an uphill battle in judiciary committee hearings of the House and Senate. Compelling testimony in favor of changing the statute came from a man who believes his wife died because of a mistake that wasn't detected until it was too late—to save her life or bring a lawsuit. It's not surprising that legislators were sympathetic.

We all want a reasonable balance. It's important for people to have recourse to the courts when they believe there has been malpractice—but justice must be swift enough so physicians are not asked to defend themselves against charges that may have occurred so long ago that memories have faded and evidence has vanished. Medicine is a rapidly chang-

ing field. Defendants would have to remember—and juries decide—based on a standard of care that has been eclipsed by later discoveries.

Emotional testimony propelled the legislation through the judiciary committees. The MMA argued that no matter where the line is drawn, some claims will fall outside the statute of limitations. The two-year statute is not rigid. Minnesota courts have often allowed claims beyond the two-year period under the "continuation of treatment" theory, which starts the clock ticking at the last date of treatment for the particular condition.

If legislators do decide that too many people with legitimate cases are falling on the wrong side of the line, the statute should be changed *only* as part of a broad tort reform effort. To consider it in isolation would go against Minnesota's efforts to hold down health care costs and reduce the number of uninsured.

Most states with a longer statute of limitations have other provisions to reduce costs. At least 10 states cap noneconomic damages; another seven states cap all damages. Twenty-one states limit attorney contingency fees.

If we make changes, we should follow California's lead and adopt comprehensive tort reform. California had the highest medical malpractice premiums in the world in 1975 when it adopted the Medical Injury Compensation Reform Act (MICRA). Among MICRA reforms were caps on noneconomic damages and limits on attorney contingency fees. By 1990, California premiums were half or a third as high as those of states without similar reforms.

We recommend that Minnesota cap noneconomic damages such as pain, suffering, and inconvenience, but not compensation for medical expenses and loss of earnings; limit attorney contingency fees, which would create an incentive to take only meritorious claims; and apportion liability based on the percentage of fault.

Tort reform can only be successful if it's comprehensive. •••••

MMA Supports Improved Bill to Address Fetal Alcohol Syndrome

The MMA has given its full support to an improved fetal alcohol syndrome bill that would allow physicians to help—but not force them to report—pregnant patients who are unable or unwilling to stop drinking alcohol.

The legislation (H.F. 3184-Skoglund), which grew out of the Governor's Task Force on Fetal Alcohol Syndrome, originally would have required a physician treating a pregnant woman who is abusing alcohol to report the patient to a local welfare agency, and would have permitted commencement of a civil commitment proceeding if the woman refused treatment.

While the MMA wholeheartedly endorsed finding more effective ways to assess and treat fetal alcohol syndrome (FAS), the bill's original language posed a potential threat to the physician-patient relationship.

Physicians worried about the possibility that some pregnant women might not seek prenatal care for fear of being reported. The MMA worked with First Lady Susan Carlson, who led the FAS task force, and the bill's authors to remove the mandatory reporting and civil commitment provisions.

The amended version of the bill would give physicians immunity both for good faith reporting and for failure to report a woman who is abusing alcohol. The new language also includes a narrower definition of "abuse of alcohol" than the bill initially did. "Abuse of alcohol" is now defined in either of the following ways: 1) the person has required detoxification for alcohol intoxication during the pregnancy, or 2) the person is found to be an alcohol abuser "through a validated chemical use assessment conducted according to rules adopted by the commissioner of human services."

At press time, the bill was awaiting its third and final reading on the House floor, and its Senate companion was awaiting a hearing in the Senate Health and Family Security Committee.

The governor's budget includes a \$5 million appropriation for research, education, and public awareness initiatives to emphasize the importance of avoiding alcohol during pregnancy. The appropriation is reflected in another piece of legislation endorsed by the MMA, S.F. 3004-Berglin.

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Malpractice continued from page 33

and underserved areas. A number of other amendments are before the Finance Division, including proposals to allow enrollees to sue HMOs, to require malpractice prelitigation screening panels, and to cap attorneys' fees.

Representatives from Medical Alley, Allina Health System, Health-System Minnesota, Minnesota Hospital and Healthcare Partnership, and the Mayo Foundation joined the MMA in testifying against the legislation. Also opposed are the Minne-

sota Dental Association, Minnesota Council of Health Plans, and Care Providers of Minnesota.

The bill to change the medical malpractice statute of limitations did not meet committee deadlines and appears dead. The session is not over, however, and the MMA is not letting down its guard.

See *Viewpoint* by Paul Matson, M.D., chair of the MMA Board of Trustees on page 34 for his thoughts on this legislation.

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1998 Membership Renewal Cycle Looks Promising

♦♦♦♦♦FIVE MONTHS INTO THE 1998 membership renewal cycle, nearly 7,000 physicians—72 percent of MMA members—have renewed their memberships. MMA staff processed over \$1.3 million in membership dues for component societies, the MMA, and the AMA in January. By mid-February, membership renewals were slightly ahead of last year.

If you have not yet renewed your membership, please do so promptly to ensure continuity of benefits and services. If you have already renewed your membership, please encourage your colleagues to renew or initiate MMA membership.

The dues processing staff, at 612/378-1875 or 800/DIAL MMA (342-5662), is happy to answer questions about MMA membership renewal.

National Patient Safety Foundation to Meet in Minneapolis

A meeting of the American Medical Association's National Patient Safety Foundation is planned for late April in Minneapolis. The NPSF aims to create a safer health care environment by helping prevent accidental injuries and deaths in the health care system. An MMA member, Eric Knox, M.D., is chair of the foundation's Prevention and Implementation Committee, which seeks to translate new knowledge into practical tools for providers to prevent injuries. Watch the next issue of *The Monitor* for more information, or e-mail the foundation at the following address: npsf@ama-assn.org

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LEGISLATIVE NEWS

MMA's DEA Bill PASSES SENATE COMMITTEE

An MMA-sponsored bill to limit use of physicians' DEA numbers for profiling and general tracking of prescription patterns was still moving forward at press time, having passed both the House Health & Human Services Committee and the Senate Health & Family Security Committee. An amendment to the bill (H.F. 2401-Huntley, S.F. 2297-Hottinger), delaying the effective date, removed any controversy surrounding the proposal. The legislation now provides that 24 months after the federal government develops a new national provider identification number, health plans, pharmacies, and drug manufacturers will be prohibited from using the DEA number for purposes other than enforcing controlled substance laws.

PROPOSAL TO LOWER LEGAL BLOOD ALCOHOL LIMIT IS ALIVE

A bill to reduce the legal blood alcohol limit for drivers from .10 percent to .08 percent was still moving toward passage as *The Monitor* went to press. The House bill (H.F. 2389-Entenza) was referred to the Judiciary Finance Division. Its companion in the Senate (S.F. 2099-Foley) passed the Senate Judiciary Budget Division and was referred to the Senate Crime Prevention Committee. The legislation's effective date was delayed from January 1, 1999, to July 1, 1999, as it would be expected to lead to more arrests and jail time, increasing costs in the judiciary system. The MMA strongly supports the .08 percent standard. Last year, a similar proposal passed the House but had difficulty in the Senate; MMA political analysts said its

passage in the Senate Judiciary Budget Division is a "positive sign."

MMA ENDORSES HOTTINGER'S ENDOWMENT BILL

The MMA endorsed a proposal by Sen. John Hottinger, DFL-Mankato, to authorize a constitutional amendment creating an endowment for Minnesota children aged 0 to 5. The amendment would be placed on the ballot for the fall's statewide elections. Hottinger's legislation was prompted in part by the MMA's "Prescription for a Healthy Baby" campaign; at a February 2 press conference introducing the bill, Hottinger pointed to MMA materials discussing the link between nurturing and brain development. Possible funding sources named by Hottinger for the endowment include a tobacco tax increase, a portion of funds from the tobacco litigation, annual legislative appropriations, and tax-deductible contributions.

'DIRECT ACCESS' PROPOSAL BECOMES A STUDY

Legislation that would have required health plans to provide "direct access" to chiropractors, optometrists, and advanced practice nurses was substantially modified in the Senate Commerce Committee. In its amended form, the bill calls for the commissioners of health and commerce to convene an ad hoc advisory panel of health plans, purchasers, and provider groups to assist the commissioners in developing "measures to address discrimination against providers and provider groups in managed care." The MMA opposed the original bill, which prevented health plans from exercis-

ing referral requirements and had the potential to interfere with continuity of care for patients. The new language mandating a study, however, was not objectionable to anyone.

CONSUMER ADVOCACY OFFICE FUNDING UNCERTAIN

Start-up financing for the proposed Consumer Advocacy Office was uncertain as *The Monitor* went to press. Creation of a Consumer Advocacy Office was recently recommended by a group of health care providers, consumers, payers, and representatives of the health and commerce departments to help patients navigate health plan appeals and complaint resolution processes. At press time, the Senate supplemental budget bill for health and human services did not contain funding for the office; MMA political analysts said the House was still considering the matter.

INDEXES, WEB SITES OFFER UP-TO-THE-MINUTE LEGISLATIVE NEWS

To obtain up-to-the-minute information on specific bills, call the House Index at 612/296-6646, or the Senate Index at 612/296-2887. For more general legislative information, call the House Information office at 612/296-2146, or the Senate Information office at 612/296-0504. The MMA home page (www.mnmed.org) links you to up-to-date legislative news: click "Legislation and Advocacy" to reach the Minnesota House, Senate, governor's office, and other state government sites. Current legislative information is also available on the Internet at the following address: www.leg.state.mn.us

Board Endorses Principles of Coalition to Save Lives, Not Tobacco

The MMA Board of Trustees has endorsed the principles of the national Coalition to Save Lives, Not Tobacco.

The Coalition includes the American Public Health Association, the American Lung Association, and former Surgeon General C. Everett Koop, M.D. Formed to give Congress input from public health advocates as it considers national tobacco legislation, the coalition vigorously opposes legal immunity and special protections for the tobacco industry.

In mid-February, Sen. Kent Conrad, D-N.D., announced legislation designed to promote smoking prevention and education, raise taxes on cigarettes, give the Food and Drug Administration (FDA) full authority to regulate nicotine as a drug, require a two-thirds reduction in youth smoking rates, and permit future lawsuits against tobacco companies. Minnesota Attorney General Hubert H. Humphrey III has said the bill, for which President Clinton has announced his support, would not affect the trial in Minnesota.

Rep. Luther Recognized for Antitobacco Efforts

Rep. Bill Luther of Minnesota's sixth Congressional district was honored by Action on Smoking and Health (ASH) for his efforts in tobacco control and protecting the rights of non-smokers. ASH is chaired by former Secretary of Health and Human Services Louis Sullivan, M.D. One of its primary goals is ensuring the Food and Drug Administration's ability to regulate nicotine as a drug.

Health Plans to Cover Smoking Cessation Products

Blue Cross and Blue Shield of Minnesota and HealthPartners announced February 18 that they will begin covering the cost of nicotine patches and nicotine gum for their members. They will also cover Zyban, an antidepressant that the federal government recently approved to help smokers kick the habit. Medica announced a similar policy change last December. ♦♦♦♦

Two More MMA Doctors Testify in Tobacco Trial

♦♦♦♦TWO MORE MMA PHYSICIANS have testified for the state in the closely watched smoking-and-health lawsuit.

Scott F. Davies, M.D., director of pulmonary and critical care at Hennepin County Medical Center, testified that smokers are at much greater risk for chronic obstructive pulmonary disease (COPD) than nonsmokers or those who quit.

Kevin J. Graham, M.D., director of preventive cardiology at the Minneapolis Heart Institute, said cigarette smoking is the "most powerful modifiable risk factor for heart disease."

The lead expert witness in the state's landmark trial against the tobacco companies was MMA member Richard D. Hurt, M.D., medical director of the Mayo Clinic's Nicotine Dependence Center and a consultant in internal medicine.

AMA Working to Correct Latest HCFA Documentation Guidelines

The American Medical Association announced in early February a campaign to correct the revised Health Care Financing Administration (HCFA) Documentation Guidelines for Evaluation and Management Services during a six-month implementation delay, effective until July. The delay was obtained by the AMA in December.

In its campaign, the AMA emphasizes:

- Advocacy to ensure that physicians are protected from unwarranted fraud and abuse penalties when

inadvertent coding or documentation errors occur, as well as ensuring the proper use of documentation guidelines and audit criteria by Medicare and other payers.

- Ensuring that refinements to the guidelines are comprehensive and result from a process through which national medical specialty societies, state medical associations, and other health care professional organizations continue to provide the AMA, the CPT (Current Procedural Terminology) Editorial Panel, and HCFA with detailed recommendations for

clarifying and improving the documentation guidelines.

- A coordinated effort between the AMA and other members of organized medicine to educate and assist physicians during implementation of the final revised guidelines and associated payer audit criteria.

AMA President Percy Wootton, M.D., said the AMA will aggressively seek to prevent physicians from being unfairly penalized or prosecuted for inadvertent coding or omissions in billing documentation.

The AMA will seek input from physicians around the nation, and is planning a work session with leaders of medical specialty societies and other physician and provider groups in April. ♦♦♦♦

HTAC Prepares Q & A on Ischemic Stroke Treatment

The Health Technology Advisory Committee (HTAC) is expected to review, at its March meeting, a question-and-answer brief on the use of t-PA in treating ischemic stroke.

An HTAC work group studying the issue reviewed an earlier draft of the brief and plans to publish a revised version of that draft this month. The t-PA work group was formed partly in answer to an MMA recommendation. The MMA House of Delegates passed a resolution at its Annual Meeting in September calling for various measures to fight ischemic stroke; among them was a recommendation that HTAC plan and implement effective strategies for promoting effective stroke management.

HTAC is an independent body, comprised of volunteers, that evaluates new and existing health technologies. The committee considers issues of safety, clinical effectiveness, health outcomes, and expense to determine whether benefits to patients and society outweigh risks and costs of a given technology. HTAC reports its findings to the bipartisan Legislative Oversight Commission on Health Care Access and works in conjunction with the state Commissioner of Health and Health Department.

If you have any questions about the t-PA work group, please call Mary Stadick of HTAC at 612/282-6355.

HTAC Seeks Nominations for Technology Evaluation

The Health Technology Advisory Committee is soliciting nominations for technology evaluation. To recommend a technology for assessment by the committee, fill out the one-page nomination fax form and return it by fax before April 1. The fax form can be obtained by calling HTAC at 612/282-6374, or by visiting the HTAC Web site. The address is www.health.state.mn.us/htac

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Health Care Coalition on Violence Announces New Award

• • • • • THE HEALTH CARE COALITION on Violence, of which the MMA is a member, and the Governor's Task Force on Violence have announced the creation of Violence Prevention: An Achievement Award for Health Care Organizations. The award will recognize health care organizations committed to the prevention, intervention, and treatment of violence. It will be presented to organizations that meet several criteria by November 1, 1998:

- Document violence through the use of E-codes, to help increase understanding of the causes and frequency of violence;
- Sponsor educational pro-

grams for health care professionals to improve their knowledge and skills in violence prevention and intervention;

- Integrate a violence prevention component in all prenatal and postnatal education classes; and

- Develop and implement a violence prevention project in collaboration with a community organization.

Eligible organizations include health systems, health plans, hospitals, and clinics. For more information, or to receive an application packet, contact the Health Care Coalition on Violence at 612/576-1825.

Nelson to Chair AMA Ad Hoc Group

Audrey M. Nelson, M.D., of Rochester was named chair of the American Medical Association's Ad Hoc Committee on Structure, Governance, and Operations.

The committee was formed, in the wake of the highly unpopular Sunbeam arrangement, to study the function and operation of the House of Delegates and Board of Trustees, "and to recommend structural and procedural changes to policies, procedures, and/or Constitution and

Bylaws that ensure propriety, efficiency, and accountability in the development of Association programs and the conduct of all activities."

The committee will work with an independent consulting firm to evaluate the AMA's internal decision-making process, and will report its findings at the 1998 AMA Annual Meeting.

Nelson, a rheumatologist at the Mayo Clinic, is a Minnesota delegate to the AMA. • • • • •

More '2 Smart' Sponsors Found

The MMA and the Smoke-Free 2000 Coalition have so far found enough sponsors to bring the anti-smoking play "2 Smart 2 Smoke" to 22 schools in Greater Minnesota. The National Theatre for Children's play entertains as it teaches that smoking is uncool. Numerous component medical societies, specialty

societies, and clinics are sponsoring performances—helping prevent children from starting to smoke while gaining recognition for their generosity. To learn more about this exciting opportunity, contact Lorrie Holmgren at the MMA at 800/DIAL MMA (800/342-5662) or 612/378-1875. • • • • •

MMA Doctor's Film on Infant Mental Health Wins Awards

A documentary on infant mental health by Gerald F. Ronning, M.D., has won two national awards. Ronning is a psychiatrist in Minneapolis. He coproduced the film with his wife, Cheryl Ronning, a producer, director, and editor.

"His Name Is Today" explores the Riga/World Association Infant Mental Health (WAIMH) Conference on the Mental Health of Infants, Children, and Families held in Riga, Latvia in 1994. The Riga conference was "an historic exchange of ideas and experiences," Ronning said. In the film, scientific presentations

are interlaced with footage of cultural exchanges and images of the streets, orphanages, and daycare centers of Riga.

The documentary will premiere in the Twin Cities area on April 16 in the Pillsbury Auditorium at Hennepin County Medical Center. The screening will be co-sponsored by Allina Health System as part of the Hennepin-Regions Psychiatry Training Program 1998 Film Series.

The film earned the 1997 Gold Award for Best Medical-Health Film at the Charleston Worldfest International Film Festival, as well as a

prominent award from the advertising industry. "His Name is Today" has been presented at several scientific meetings in Europe, Canada, and the United States. Other screenings may be scheduled in Minnesota, Ronning said.

The Ronnings also produced 10 audiotapes of scientific presentations from the conference. The film and the audiotapes have been made available for sale to the international community by the World Association for Infant Mental Health. In Minnesota, order forms can be obtained by calling Persephone Productions at 612/630-2202. A portion of all sales benefit WAIMH. ♦♦♦♦♦

ANNOUNCEMENTS

MINNESOTA MEDICINE SEEKS SCIENTIFIC SUBMISSIONS

Minnesota Medicine, the award-winning monthly journal published by the Minnesota Medical Association, is seeking scientific papers, clinical studies, review articles, and case reports from member physicians. If you are interested in submitting material for consideration (manuscripts will undergo peer review), contact the editors at 612/378-1875 or 800/342-5662, send an e-mail to mm@mnmed.org, or write to *Minnesota Medicine*, 3433 Broadway St. NE, Suite 300, Minneapolis, MN 55413. Author instructions are published in each issue of the journal.

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JOURNAL SEEKING PHYSICIANS WITH UNUSUAL HOBBIES

Do you or one of your colleagues have an offbeat hobby? *Minnesota Medicine* staff are looking for MMA members with unconventional leisure-time pursuits to feature in an issue devoted to physician avocations. Contact editors Meredith

McNab, Susan Rodsjo, or Lee Engfer by April 15 at 612/378-1875 or 800/DIAL MMA (342-5662); send an e-mail to mm@mnmed.org; or write to *Minnesota Medicine*, 3433 Broadway St. NE, Suite 300, Minneapolis, MN 55413.

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MEDICA WILL RETURN RESERVE FUND MONEY TO PHYSICIANS

Medica will return 82.8 percent of the Physician Contingency Reserve money to physicians. A significant financial recovery made it possible for the Medical Board to make this decision. Physicians should receive their checks this month.

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DR. SATCHER CONFIRMED AS SURGEON GENERAL

David Satcher, M.D., won Senate confirmation as Surgeon General on February 10, after a three-year vacancy in the post. Satcher, director of the Centers for Disease Control and Prevention in Atlanta, was endorsed by the American Medical

Association for the position. But his nomination had been opposed by some conservatives who were troubled by his support of a study examining the effectiveness of needle-exchange programs in HIV prevention, and by his agreement with President Clinton that a ban on intact dilation and extraction should include an exception for the health of the mother. Satcher's confirmation was approved 63-35.

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GRANT TO HELP PROMOTE APPROPRIATE PAIN MANAGEMENT

The Federation of State Medical Boards' Research and Education Foundation has received a grant from the Robert Wood Johnson Foundation to use in developing guidelines to help state medical boards monitor the prescribing of controlled substances for the management of chronic pain. The guidelines will be designed to help state medical boards clarify their expectations of physicians who are prescribing opioids and other controlled substances for pain relief.

MMA Joins Buckle Up America

.....WHILE THE MINNESOTA Senate was rejecting a bill to make seat belt violations a primary offense, the Minnesota Medical Association joined the national Buckle Up America initiative.

Buckle Up America, spearheaded by the National Highway Traffic Safety Administration, aims to increase national seat belt use to 85 percent and reduce child occupant fatalities by 15 percent by the year 2000—primarily through stronger seat belt laws. Its goals are in keeping with a resolution passed at the 1997 MMA Annual Meeting. In Resolution 303, the MMA House of Delegates vowed to pursue a primary seat belt law and to conduct a public education campaign on the importance of seat belt use.

The NHTSA predicts that Minnesota could save 48 lives, prevent over 1,200 injuries, and save close to \$80 million each year by upgrading from secondary to primary seat belt enforcement laws. If every state upgraded to primary enforcement laws, the NHTSA estimates that 1,736 fatalities could be prevented, and \$2.8 billion could be saved nationwide.

The MMA-backed legislation that would have allowed police to stop and ticket drivers solely for failure to wear a seat belt was defeated in a 33-27 vote on the Senate floor. Foes of the bill, mostly from rural and suburban districts, argued that it infringed on individual freedom.

The Minneapolis-based *Star Tribune* quoted Sen. Charlie Berg, an independent from Chokio, summarizing opposition to the measure: "I think seat belts are unnecessary and an infringement on your right to use your own judgment."

The bill's author, Sen. Leo Foley, DFL-Anoka, is a retired state patrol officer. He testified that in 33 years as a state trooper, "I never unbuckled anybody who was in a fatal car crash."

NHTSA statistics show that the "personal choice" not to wear seat belts leads to higher insurance costs for all Americans. Inpatient hospital care costs for an unbelted crash victim are 50 percent higher than those for a belted crash victim, the NHTSA said.

MMIHC Acquires MedPower Information Services

Midwest Medical Insurance Holding Company (MMIHC) announced in early February that it has acquired the assets and holdings for MedPower Information Services (MedPower).

MedPower is a neutral and independent provider of health care transaction processing, information management, and technology services. Its primary business is the electronic submission of claims on behalf of thousands of providers to numerous payer organizations.

In a letter sent February 6 to all of MMIHC's insureds, President David P. Bounk and Board Chair Andrew J.K. Smith, M.D., explained the implication of the acquisition: "Over time, by combining our resources, we intend to provide expanded services and technology for the accumulation, analysis, and use of claims and encounter data to add value to medical and hospital practices."

Doctors May Wait Longer for Medicare Claims Processing

According to United HealthCare (Minnesota's Part B Medicare carrier), the Health Care Financing Administration (HCFA) is implementing some changes to reduce program costs. Among them is a provision that will result in a delay in payment for Medicare claims submitted electronically.

United HealthCare Medicare currently processes checks on a daily basis for electronic claims with a date of receipt of 14 days earlier. HCFA is requiring that this "one-day window"

be extended to a seven-day window.

The implication of this change is that physicians may have to wait up to 20 days, rather than 14 days, for Medicare to issue a check. The change was to be phased in through February and early March, and will be in full effect March 16.

Medicare also is extending the payment window for paper claims, from the three-day window of 27-29 days to a four-day window of 27-30 days.

The Monitor

MARCH 1998

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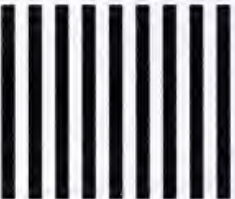
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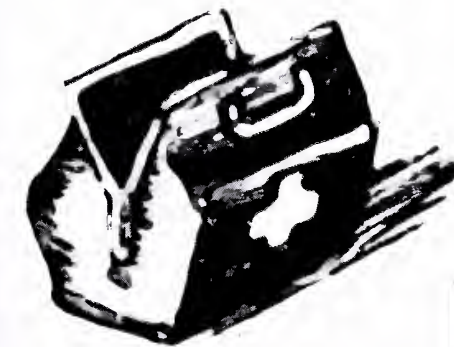
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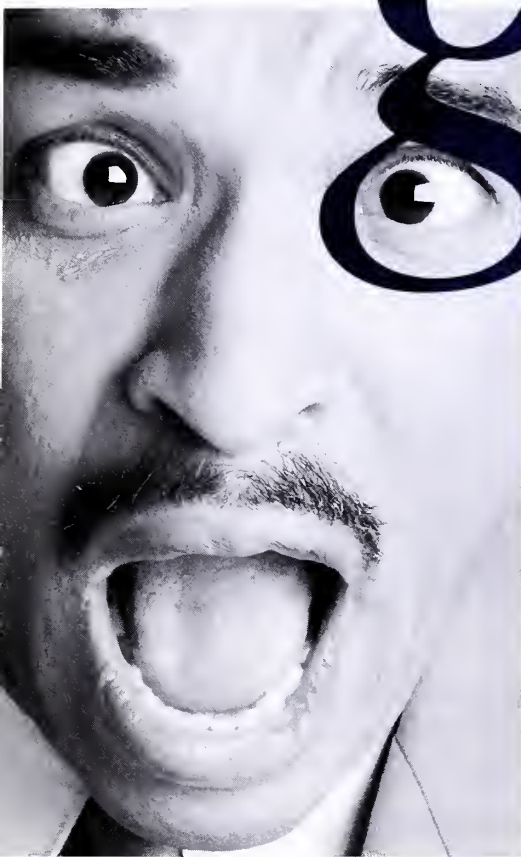


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White Coats on Picket Lines?

"When Doctors Join Unions" and "Death of the Guilds: Professions, States and the Advance of Capitalism" call on docs to reclaim professional power.

Reviewed by Charles R. Meyer, M.D.

The picket line moved slowly. White-coated strikers with stethoscopes slung around their necks carried signs saying, "US Megacare unfair to doctors."

Wait a minute. Doctors don't strike. Or do they? Although doctors' unions have surfaced briefly over the past 60 years and Canadian physicians have staged a few work "slow-downs," the notion that M.D.s could and would unionize and strike has seemed as improbable as a Harold Stassen presidency. Yet American doctor unions do exist (see the cover story, page 10). The most durable, the Union of American Physicians and Dentists (UAPD), formed in 1972, is the subject for Gladys Budrys's book, *"When Doctors Join Unions"* (Cornell University Press, 1997). Her analysis of the need for physician unions is complemented by Elliott Krause's book, *"Death of the Guilds: Professions, States and the Advance of Capitalism, 1930 to the Present"* (Yale University Press, 1996), a multiprofessional, multinational perspective on the decline of professional power.

Founded by charismatic firebrand surgeon Sanford Marcus, M.D., the UAPD rose from the cauldron of medicine in the early 1970s. Medicare and Medicaid had thrust the muscle of the federal government into medical practice. Paul Ellwood had coined the term HMO, which was rapidly becoming a four-letter word for doctors. And hospitals, especially in Marcus's native California, were

merging and maneuvering. Marcus's epiphany came at a meeting where a hospital administrator peremptorily told the assembled doctors that the hospital had formed an HMO the doctors would join. Galled by physicians' mounting impotence to direct their practices, Marcus drafted a letter predicting the demise of physician independence, sent it to 5,000 M.D.s asking each to contribute \$25, and received 250 paying replies. On April 18, 1972, the UAPD was born with a charter calling for optimum medical care, quality facilities, doctors unhindered by extraneous forces, and reasonable compensation for physicians.

The physician frustration that spawned the UAPD led to the creation of 26 other unions in the 1970s, most of which flashed on the scene in response to a single issue and sputtered either as the issue was resolved or as physicians were unable to unite behind a common purpose. The UAPD has survived to this day, partly through Marcus's galvanizing personality and partly through the union's creative flexibility.

The UAPD has had to fish for a constituency and tailor its tactics. Initially, because of antitrust legislation, only salaried physicians employed by the state of California could bargain as a group. Today the UAPD has a bimodal membership. Salaried physicians employed by any institution and who are not classified as supervisors can be represented by the UAPD in actions like the 1975 Cali-

fornia anesthesiologists' protest over malpractice premiums, in which the UAPD mediated the final negotiations. The current swell of salaried physicians is a potential membership gold mine for this segment of the UAPD. Private practice docs can join UAPD to benefit from the union's lobbying efforts, court action, and negotiation prowess. Neither segment of the union has participated in UAPD-organized and -directed strikes in the union's 26-year history. White coats on picket lines remain a rarity.

While the UAPD has battled for legal standing, it also has struggled for professional respect. Although the AMA recently formed a division of physician representation, it has traditionally denigrated unions as unprofessional. Sensitive to the charge that unions and professionals are oil and water, Budrys spends much of her book dissecting the concept of professionalism and trying to square it with union participation. She labels physicians before 1970 a precapitalist guild: "Doctors ... come closer to being 'intellectual craft workers who have maintained many of the characteristics of a craft community, even a guild. They do, after all, train new members, develop new skills and techniques within their own ranks, and maintain close ties outside of working hours that reinforce the sense of community.'" She believes these traits are not lost by joining a union but are threatened by the corporate takeover of medical care.

Budrys's view of physicians' tra-

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ditional role echoes that of Edwin Krause in his recent book, "Death of the Guilds: Professions, States and the Advance of Capitalism, 1930 to the Present." Krause defines guilds as groups with similar skills who wield power over their association, their workplace, their market, and their relation to the state. Although Krause expands his analysis to other professions, like law and engineering, and to other countries, like Britain and France, medicine in the United States is the focus of his lesson. American medicine prior to 1970 fit most of his guild criteria. But after 1970 the medical guild lost its power; government tightened its regulation in response to rising costs, corporations attempted to rationalize medical care delivery, and medicine "Balkanized," with specialties scattering to negotiate with government and purchasers. That's what created the UAPD: lost power leads to a search for power.

Budrys is an unabashed cheerleader for the UAPD. Her defense wanders into strange alleys, like an essay on "postindustrial" workers,

which leads to stretched analogies and dead ends. She tries, but fails, to explain why a union that uses lawsuits and education as tools rather than strikes and pickets is anything more than a physician management company. Krause, on the other hand, hopes that a consumer movement will trigger a resurrection of the lost safeguards of the guild era with re-deemed professional control.

Budrys and Krause share a common vision of the past; both believe that medical practitioners have lost control of their guild to corporation and government. Krause calls for consumers to reclaim their power in the medical marketplace and help physicians regain guidance of medical care. Budrys calls for docs to embrace the power politics of Sanford Marcus and grab a picket sign to reclaim their guild. **MM**

Charles Meyer is editor-in-chief of Minnesota Medicine and an internist with Consultants-Internal Medicine in Minneapolis.

WE ARE PLEASED TO ANNOUNCE THAT Mary Jane Chiasson, D.O., Francisco J. Gomez, M.D. and Michael P. Sethna, M.D. HAVE JOINED OUR PRACTICE



Doctor Chiasson received her medical degree from Michigan State University. She served her general rotating internship at Grand Traverse Community Hospital in Traverse City, Michigan and her internal medicine internship at the University Medical Center in Tucson, Arizona.

Doctor Chiasson completed her residency in neurology at the University Medical Center in Tucson. She practiced in Missouri before joining the Noran Neurological Clinic. She has a special interest in headache and pain management and is board eligible in neurology.

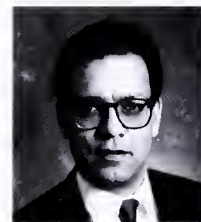
Doctor Chiasson will primarily practice at our 910 Medical Place office in Minneapolis. She will also see patients in Faribault and Shakopee.



Doctor Gomez received his medical degree from the University of Iowa in Iowa City, Iowa. He also completed his internal medicine internship and residency in neurology at the University of Iowa.

Doctor Gomez was a neurologist in Decatur, Illinois before joining the Noran Neurological Clinic. He was also Director of the Neurophysiology Laboratory at Decatur Memorial Hospital. He has a special interest in stroke and headache and is board certified in neurology.

Doctor Gomez will primarily practice at the Unity Professional Building in Fridley. He will also see patients in St. Cloud and Mora.



Doctor Sethna received his medical degree from the Mayo Medical School and served his internship at Beth Israel Hospital in Boston, Massachusetts.

Doctor Sethna completed his residency in neurology at the New York Hospital/Cornell Medical Center in New York, New York. He also has a Ph.D. in immunology from the Harvard Medical School. Doctor Sethna has been a neurologist in private practice in Massachusetts. He has a special interest in headache, epilepsy and multiple sclerosis, and is board certified in neurology.

Doctor Sethna will primarily practice at our 910 Medical Place office. He will also see patients in Maplewood and Shakopee.

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People and Places Making Medical News

People

Onstad Honored with Minnesota Laureate Award

Gerald Onstad, M.D., a gastroenterologist at Hennepin County Medical Center, received the Minnesota Laureate Award for 1997 from the American College of Physicians (ACP). The award honors Minnesota ACP members who have demonstrated an abiding commitment to excellence in medical care, education, research, and service to their community, their chapter, and the American College of Physicians. According to ACP, "[Dr. Onstad] is an outstanding teacher who willingly gives continuously of himself to the needs of his students, residents, fellows, and patients."

Medical Alley Appoints New Board Members

The Medical Alley board of directors in February elected Pamela Tibbetts and James Woodburn, M.D., to serve on the association's board. Tibbetts is senior vice president at Fairview Health Systems in Minneapolis. Woodburn is medical director at Blue Cross and Blue Shield of Minnesota in Eagan. Medical Alley is a not-for-profit trade association representing nearly 250 health care organizations in Minnesota.

Places

Children's Health Care Gets New Name

Children's Health Care has changed its name to Children's Hospitals and Clinics. The two hospitals in the organization, formerly Children's Health Care—St. Paul and Children's Health Care—Minneapolis, are now Children's Hospitals and Clinics in St. Paul and Children's Hospitals and Clinics in Minneapolis.

Hospital officials hope the new name will better reflect the organization's scope of services and will end the confusion generated by the old name.

'U' Medical School Faculty Offered Early Retirement

The University of Minnesota will offer early retirement this spring to some senior members of the Medical School faculty, said Alfred Michael, M.D., dean of the school, in an address in January. The offer is intended to create advancement opportunities for young faculty members and to make it easier for senior faculty members to retire if they choose. About 40 to 50 of the school's full-time faculty members would qualify for early retirement; those who accept the offer will receive small pay increases in the next two years and could continue their teaching and research.

Socioeconomics

Family Health Services and Medica Sever Ties

Medica, the state's largest HMO, and a group of health clinics in the east-metro area of Minneapolis-St. Paul will terminate their relationship at the end of the year, forcing 20,000 people to switch doctors or health plans.

After failing to reach an agreement after more than a year of contract negotiations, the 15 clinics of Family Health Services of Minnesota will split from Medica. Members of Medica Choice who go to MinnHealth Family Physicians Clinics or East Metro Family Practice Clinics, all operated by Family Health Services, will have a year to choose whether to stay with their physicians and clinics or with Medica.

At the heart of the dispute is a disagreement over provider access. Medica wanted patients to be able

to choose their primary care physicians and specialists from among all 9,000 doctors in Medica's network. The clinics wanted to have their patients stay within their network of about 80 primary and 250 specialist physicians. Medica argued that its patients demanded the right to choose their caregivers.

But that choice imposes physician and clinic payment policies that hurt patient care, said Family Health president Keith Oelschlager, M.D. "Medica is not doing well financially," he told the Minneapolis-based *Star Tribune*. "The only way they can control costs is to control services or make it difficult to obtain services."

Tom Luchi, CEO of Family Health Services, said he expects about half of the clinics' patients to switch health insurance carriers in order to stay with the clinics' physicians.

Task Force Aims to Prevent Alcohol Use During Pregnancy

Pregnant women should be urged not to drink at all, according to a report from a governor's task force on fetal alcohol syndrome, and if a woman will not or cannot stop drinking, she should be committed to a treatment program. The report, released February 5, was immediately endorsed by Gov. Arne Carlson, who asked the Legislature for \$5 million to establish a program offering education, research, and treatment.

The task force, headed by Susan Carlson, a Minnesota district court referee and wife of Gov. Carlson, and Hennepin County District Judge Joan Erickson Lancaster, drove home a clear, strong message in its report: pregnant women cannot drink.

Women in Minnesota tend to be heavier drinkers than women in most other states; 17.6 percent of women aged 18 to 44 say they consume more than 30 drinks a

month or five or more drinks at a time, according to an article in the *Saint Paul Pioneer Press*. Fetal alcohol syndrome is the No. 1 cause of mental retardation and developmental disabilities in Minnesota.

The task force recommended that the mandatory reporting law for illegal drugs be expanded to include alcohol abuse by pregnant women. The commitment recommendation is also similar to laws that already exist for pregnant

women who use illegal drugs. To find out if pregnant women are drinking too much, physicians and nurses would be expected to ask women they see for prenatal care how much they're drinking. They would also be expected to commit a pregnant woman who did not voluntarily enter treatment for alcohol abuse.

The MMA Board of Trustees strongly supports the \$5 million appropriation for FAS prevention and treatment but has concerns about requiring physicians to force pregnant women who can't or won't stop drinking into treatment programs. (For an update on legislative action on this issue, see this month's *Monitor*, page 35.)

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Minnesota, Norway Cooperate on Clinical Trials

Gov. Arne Carlson and Norwegian Minister of Health Dagfinn Høybråten signed a declaration of cooperation in clinical medical trials in February. The initiative will provide Minnesota medical technology companies with access to the Norwegian clinical system, allowing them to evaluate, test, and approve new medical devices expediently. With this cooperation, Minnesota companies hope to save time and money in bringing medical products and devices to market in Europe and the United States.

"We think that many Minnesota-based technology companies can significantly benefit from easier access to European sites for clinical trials," said Carlson. "This expanded cooperation between Norway and Minnesota will allow for new medical products and services to become available on the market."

Growth in Health Spending Slows

For the first time, health care costs in the United States exceeded \$1 trillion in a single year—1996—but the government said annual spending increases are slowing. Spending on health care averaged \$3,759 per person in 1996, up \$126 from 1995, accord-

ing to the Department of Health and Human Services. But average annual growth in total health spending dropped to 4.4 percent, a record low.

Low inflation, more people in managed care, and curbs on government spending all contributed to slower expansion of health care spending, the Health and Human Services Department reported. Health spending grew an average of 11 percent a year during the 1980s.

Physicians and hospitals are getting a smaller share of the pie—54.1 percent in 1996, compared with 57.6 percent in 1990. More money is being spent on nursing homes, home health aides, and alternative care.

Minnesotans spent \$15.6 billion on health care in 1996, a 6.2 percent increase over 1995, according to Lynn Blewett, director of health economics for the Minnesota Department of Health. On average, each Minnesotan spent \$3,391 on health care in 1996, \$368 less than the average American.

Employers Kept Health Costs Down in 1997

Employers, including large companies in Minnesota, held down health care costs in 1997, but most companies predict higher expenditures for 1998, according to a William M. Mercer Inc. study of nearly 4,000 employers. Nationally, the cost of health benefits at public and private employers with more than 10 workers averaged \$3,924 per employee in 1997, an increase of only 0.2 percent over the amount paid in 1996.

Among the 42 large Twin Cities companies surveyed, health benefits costs rose 0.3 percent to \$4,012 per employee. That was lower than the 0.9 percent increase reported by large national employers, whose costs averaged \$4,369 per employee.

Many employers tried to contain health care costs by moving to managed care plans, the study found. Eighty-five percent of all employers in the United States are now enrolled in some type of

managed care plan, with 35 percent offering a preferred provider plan and 30 percent offering HMOs. Many employers are also cutting retiree benefits, which helped lower costs last year. Most survey respondents expect health care spending to increase in the next two years, however.

Rates, Trends, Data

State Reports 1996 Health Statistics
The number of births and deaths in Minnesota changed only a fraction in Minnesota from 1995 to 1996, while the number of homicides remained exactly the same, according to the Minnesota Department of Health's annual health statistics report. Other findings comparing data from 1996 and 1995 show that the population on the whole grew by 1.2 percent; the infant mortality rate decreased by 13.2 percent; and infant (under one year of age) deaths fell by 11.7 percent.

On an average day in 1996, 102 Minnesotans died. The leading cause of death was heart disease, followed by cancer and respiratory conditions. Other major causes of death included strokes, diabetes, and violent deaths.

AIDS Deaths Plummet in 1997

AIDS deaths across the United States dropped 44 percent in the first half of 1997, reflecting the success of new treatments in controlling the disease. Prescriptions of three-drug combinations—two older AIDS drugs plus a protease inhibitor—have revolutionized AIDS care.

"We can't see the end of the epidemic, but it's the beginning of a new era," said Kevin DeCock, M.D., of the Centers for Disease Control and Prevention in Atlanta.

Deaths from AIDS peaked in 1994 and 1995, then fell in 1996. Last year, the decline accelerated. According to the CDC, 12,040 Americans died of AIDS in the first half of 1997, compared with 21,460 in the first half of 1996.

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deaths from AIDS during the first 10 months of 1997, compared with 180 for 1996.

Medical School Applications Decline

For the first time in nearly 10 years, medical schools are reporting

a decline in applications. The number of students who applied for the fall of 1997 dropped 8.4 percent from the previous year, when a record 46,968 people competed for 16,000 first-year slots, according to the Association of American Medical Colleges.

Medical Research

Study: Secondhand Smoke Hastens Atherosclerosis

Exposure to secondhand tobacco smoke significantly accelerates atherosclerosis, researchers at the University of Minnesota and elsewhere found. An estimated 30,000 to 60,000 annual deaths in the United States can be attributed to passive smoke, according to a study reported in the January 14 *Journal of the American Medical Association*. The study was the first to link passive smoking with narrowing in the carotid arteries.

People who had smoked an average of one pack a day for 33 years had a 50 percent increase in the progression of the hardening of their arteries compared with nonsmokers. Among past smokers, researchers found a 25 percent faster rate of progression. Nonsmokers who reported exposure to secondhand smoke for an average of 18 to 20 hours a week had a 20 percent increase in progression.

"This is strong evidence that exposure to secondhand smoke can have a serious health consequence with respect to heart disease," said University of Minnesota epidemiologist Paul McGovern, Ph.D., one of the study's coauthors, in a *Star Tribune* article.

Innovations

FDA Approves First Implantable Cardiac Monitor

Medtronic Inc. has received approval from the U.S. Food and Drug Administration to sell what the company says is the world's first implantable cardiac monitor. The Reveal Insertable Loop Recorder is designed for patients who have fainting spells. The device, which is placed under the skin of the chest, can monitor electrocardiogram data over a year, including information about fainting spells. MM

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Letter

Continued from page 9

nearly 5 million enrollees. I find it ironic that United HealthCare, a for-profit HMO (with the highest revenues among Minnesota HMOs) is headquartered in a state that forbids for-profit HMOs.

Here in the managed care wilderness outside Minnesota, I've learned a few things about how Minnesota compares with the rest of the country:

- the managed care evolution that took 25 years in Minnesota is occurring in two to five years in less penetrated managed care markets;
- what still differentiates you from other states is your large group practices;
- what you look at with disdain—for-profit health care—is the rule elsewhere;
- what's virtually unknown in Minnesota—physician practice management companies—is the single most powerful force driving physicians into groups in other parts of the country;
- and what slows the spread of managed care in other states, you have in abundance—an infrastruc-

ture that knows how to make managed care work.

Probably the most distinguished and distinguishing aspect of health care in Minnesota is your leaders' constancy, durability, and devotion to the Minnesota ethic—physicians working together with other community stakeholders to do what needs to be done for the good of the community. Some names that come to mind are Bill McQuire, Jim Reinertsen, Gordon Sprenger, Scott Anderson, Jim Ehlen, Andy Czajkowski, George Halvorson, and Bob Waller. These leaders and others have created the Minnesota Model, a mature managed care system based on a consensus of home-grown health organizations, low capitation rates, discounted fee-for-service, and the reluctance of national for-profit managed care organizations to enter Minnesota markets.

When I talk to physician friends back in Minnesota, I find that most of them accept managed care as inevitable, but many still resist monolithic systems ruled from hospitals or managed care boardrooms. Physicians, in Minnesota as elsewhere, seek a full business partnership in managed care organizations

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so they can share in the rewards of assuming the risk for care for which they are financially and medically responsible. Conventional wisdom holds that multi-specialty groups of 20 or more, anchored by primary care physicians, will be the main vehicle for physician-directed enrollee-friendly managed care.

But specialty groups will have a place in the sun, too. Specialists—who've unjustly borne the blame for health care inflation—have a historic opportunity. Managed care is being redesigned on the frontier. In response to consumer backlash against primary care gatekeepers, health care purchasers are launching new programs to give members open access to specialists. This is an unprecedented chance for well-financed and well-organized specialty groups and networks to develop cost-effective disease management programs around the dozen or so fields, such as women's health, cardiovascular disease, musculoskeletal disease, and cancer, that consume much of our resources. Diabetes, for example, accounts for 15 percent of health care spending. Specialists, it seems to me, have an opportunity to prove that their knowledge of disease

and mastery of technology bring value, lower costs, and patient satisfaction.

In the end, I believe the winners in the health care marketplace will be those who can deliver the best value and most convenient service to payers and consumers—a physician-centric professional model or a business-centric commercial model. The single best thing organized medicine can do for physicians is to help them acquire the financial, managerial, and information tools they need to compete in a market-driven health system. In Connecticut, where I'm now licensed to practice, the state medical society has done this by creating a management services organization supported by outside management and capital partners. Physician-centered organizations, given enough capital, motivation, and discipline, will not only survive—they will prevail.

Richard Reece, a pathologist, was Minnesota Medicine's editor-in-chief from 1975 through 1990.

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Family Medicine	March 12-13
Occupational Medicine Update	March 20
NIOSH-Approved Spirometry Training	March 30-31
OB/Gyn Update	April 3-4
Fitting the Work to the Worker:	
• Pre-placement Evaluation	
• Advanced Medical Case Management	May 28-29

In 1996, the HealthPartners Institute for Medical Education (IME) was created to support the ongoing development of excellence in clinical practice through a wide variety of educational services. The Institute has development, coordination and oversight responsibilities for the undergraduate, graduate and continuing education initiatives for health professionals within the various divisions of HealthPartners including Regions Hospital.

FOR FURTHER INFORMATION CONTACT:

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CIME

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MARCH 1998

Mar. 8-11 **Neurology in Clinical Practice** Mayo Foundation; Silvertree Hotel and Wildwood Lodge, Snowmass Village, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-13 **Selected Topics in Internal Medicine** Mayo Foundation; Maui Prince Resort, Maui, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 12-13 **Family Medicine Today** Family Medicine Department at Regions Hospital and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 20 **1998 Emergency Medicine Conference** St. Mary's/Duluth Clinic Health System; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Diane Torvick, 400 East Third Street, Maildrop 5AV2ME, Duluth, MN 55805; 218/725-3838.

Mar. 20 **Nineteenth Annual Occupational Medicine Update** HealthPartners Institute for Medical Education; Sheraton Metrodome, Minneapolis, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 20-21 **Advanced Life Support in Obstetrics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

Mar. 29-Apr. 3 **Advanced Management Program for Healthcare Executives** University of Minnesota Carlson School of Management and Mayo Clinic; Leighton Auditorium, Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

APRIL 1998

Apr. 3 **ENT Update** HealthEast, Regions Hospital, and HealthPartners Institute for Medical Education; St. Joseph's Hospital, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

March 11 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

April 17-18 **North Central Chapter of the Infectious Diseases Society of America** Mayo Clinic; Radisson Plaza Hotel Minneapolis, 35 South 7th Street, Minneapolis, MN. CONTACT: Mary Majerus, Mayo Clinic, Division of Clinical Microbiology-Hilton 470, 200 First Street SW, Rochester, MN 55905; 507/284-3021.

May. 8 **Emerging Infections in Clinical Practice** University of Minnesota; Minneapolis Airport Marriott, Bloomington, MN. CONTACT: Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 23 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Apr. 3-4 **Ob/Gyn Update** Ob/Gyn Department at Regions Hospital and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Apr. 6-8 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; Scottsdale Princess Resort, Scottsdale, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 16-17 **Critical Care 1998** Critical Care Department at Regions Hospital and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Apr. 16-18 **Fractures and Dislocations of the Wrist, Elbow, and Shoulder** Mayo Foundation; Pointe Hilton Resort on South Mountain, Phoenix, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 17 **Depression and Mood Disorders: Treating Today's Woman** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

Apr. 17 **14th Annual Heart Conference** St. Mary's/Duluth Clinic Health System; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Diane Torvick, 400 East Third Street, Maildrop 5AV2ME, Duluth, MN 55805; 218/725-3838.

Apr. 17-18 **Youth and Sports: Contemporary Issues for the Primary Care Physician** Children's Health Care; Madden's Resort, Brainerd, MN. CONTACT: Betsy Julius, Medical Education, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-5884.

Apr. 23-24 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 24-25 **Neuroscience Summit: What's New Today and Looking to the Tomorrows** St. Luke's Hospital and Regional Trauma Center; Holiday Inn, Duluth, MN. CONTACT: Cheryl Jurek, Education Department, 915 East First Street, Duluth, MN 55805; 218/726-5449.

MAY 1998

May 5-8 **Fifth International Surgical Pathology Symposium** Mayo Medical Laboratories; Munich, Germany. CONTACT: Kathy Bates, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; E-mail: Kbates@mayo.edu, 507/282-0461.

May 15 **Medical Management of the Surgical Patient** Hennepin County Medical Center; HCMC, Minneapolis, MN.

CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 15-16 **John I. Coe Symposium and Minnesota Society of Pathologists Meeting** Hennepin County Medical Center; Radisson Hotel South, Bloomington, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 22 **Poisonous Mushrooms** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 30 **Critical Care: A Team Approach** Mayo Foundation; Mayo Clinic, Phillips Hall, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

JUNE 1998

June 4-6 **Fifth Annual Mayo Interventional Cardiology Symposium** Mayo Foundation; Leighton Auditorium, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 17-20 **62nd Annual Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota Medical School Department of Surgery; Willey Hall, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 800/776-8636.

JULY 1998

July 16-18 **Management Strategies in Hematologic Oncology** Mayo Medical Laboratories; Ihilani Resort and Spa, Kapolei, Oahu, HI. CONTACT: Kathy Bates, 200 First Street SW, Rochester, MN 55905; 507/284-3942.

July 29-31 **Mayo Multidisciplinary Symposium on Platelets, Blood Vessels, and Extracorporeal Medicine** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

AUGUST 1998

August 9-11 **Success with Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Chateau Whistler, Whistler, British Columbia, Canada. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

SEPTEMBER 1998

Sept. 11-13 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center; Radisson Arrowwood, Alexandria, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

Sept. 16-19 **First National Conference on Infanticide: Asphyxiation, Shaken Baby, and Neglect** Hennepin County Medical Center; St. Paul Radisson, St. Paul, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

Sept. 18 **Annual Contemporary Issues in Hemodialysis** Hennepin County Medical Center; Sheraton Midway Hotel, St. Paul, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262, or fax 612/904-4210.

OCTOBER 1998

Oct. 1-2 **Annual Forensic Science Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

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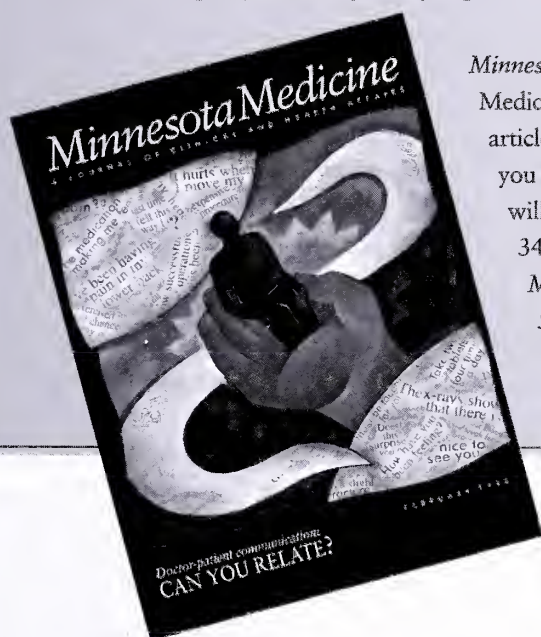
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Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: occupational medicine, dermatology, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

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Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Physician Opportunity: Minneapolis/St. Paul, Duluth, and Moorhead, Minnesota; MD wanted for part-time hours in multidisciplinary office. All inquiries to Integrated Health-Care Services, doctor's private line, 612/386-6908. (1/98-R)

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Urban Devotion

Be a living expression of God's kindness.

—Mother Theresa

I am writing this on St. Patrick's Day. So, 'tis appropriate that this *Minnesota Medicine* is about saints. While none of our "saints" is likely to gain papal recognition or can claim to have converted entire nations, all the urban medicine workers described in this issue are changing our cities as Mother Theresa did—one life at a time.



Hilfiker enough to title his 1994 book "Not All of Us Are Saints." Hilfiker began his postmedical school journey, chronicled in "Healing the Wounds: A Doctor Looks at His Work," as a solo family practitioner on Minnesota's Iron Range. From there he moved to a community clinic in inner-city Washington, D.C. In "Not All of Us Are Saints," he defines this practice as "poverty medicine," which he says is less about medicine than about class, race, culture, and medical helplessness. Medicine is about how to treat TB; poverty medicine is about how to treat TB in non-English-speaking immigrants.

In Washington, Hilfiker found himself "enmeshed in the crumbling relationship between government and poor," which threatened to erode his spirit. Despite years of sacrificial service, Hilfiker seems almost disappointed to have fallen short of sainthood.

But "Not All of Us Are Saints" is not a hopeless book. For hope, Hilfiker returns to the people: "[I]n the midst of all this ... I experience inexplicable hope. If I have learned anything, it is that many of the people with whom I work are heroes, people who struggle against all odds and survive; people who have been given less than nothing, yet find ways to give." Like some of our urban medicine workers, he and his co-workers were sustained by sturdy religious faith and remarkable devotion to the city's forgotten.

Driving the snakes out of Ireland was no easy trick, but treating disease with poverty as a comorbidity just might be harder. St. Patrick and Mother Theresa are tough acts to follow. Yet the near-saints described in the following pages are writing a form of medical hagiography by lacing their medicines with a tincture of love to heal the wounds of our urban Twin Cities—one life at a time.

.....
—Charles R. Meyer, M.D., Editor-in-Chief

.....
"Ethnic diversity, crime, family disruption, and drugs generate medical fallout that challenges even the most dedicated docs."

they see hope. Where others experience depression, they feel joy. Where others find unanswerable questions, they find solutions. And, where many of us let the world define us and our work, they are defined by their ideals.

Urban medicine faces an intimidating task. Although the Twin Cities' urban problems are minor league compared with Chicago's or New York's, ethnic diversity, crime, family disruption, and drugs here generate medical fallout that challenges even the most dedicated docs.

Yet daunting challenges seem to fuel our saints. Joy-filled is how Julia Joseph-Di Caprio, M.D. (profiled on page 6), describes her work with adolescents at risk. Hope is what Kate Cavett and John Harrington offer the gang kids they encounter in the Hand in Hand program (see our special report, page 28). Solutions are what Lowell Stoltzfus, M.D., and Hennepin County Medical Center (featured on page 14) are seeking for their patient community. And ideals are what send the family practice residents of Regions Hospital out to mission, clinic, and high-rise (see page 10).

Sainthood is an elusive status that none of these medical people would claim, or perhaps even seek. Yet it intrigued David

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A Country Doctor's Sad End

I enjoyed your review called "The Poetry of Country Doctoring" in the February 1998 edition of *Minnesota Medicine*. In fact, after reading it, I ordered David Loxterkamp's book. However, I have some sad information in follow-up to the fine book you also reviewed, "A Fortunate Man," by John Berger, about English general practitioner Dr. John Sassal. Perhaps overcome by his "overworked and proud of it" attitude and not helped by his "calculated distance from the villagers," Dr. Sassal later committed suicide, according to the very fine book, "A Doctor's Dilemma: Stress and the Role of the Carer," by Dr. John W. Holland. Dr. Holland argues

that much stress in medicine arises because of conflict between patient and doctor and attempts through his psychoanalytic training to provide ways for physicians to defuse their stress and make themselves and their patients more satisfied with medical encounters. This book would be a good complement to *Minnesota Medicine's* article in the same issue about doctor-patient communication.

James M. Welters, M.D.
Northwest Family Physicians
Plymouth, Minnesota

A Promising Prescription

My compliments on your December issue. It was encouraging to see such a thoughtful discussion of the linkage between medicine and

parent education. I was excited to read about the MMA's "Prescription for a Healthy Baby" project.

As communities work to develop preventive health strategies, it is clear that good parenting holds the most promise for preventing many of the physical and emotional maladies that beset children and teens. If kids are provided support, good limits, and a positive vision of the future, they are many times more likely to avoid the risk-taking behavior that can be so devastating to them and their families.

Keep up the good work.

Scott Richardson
Northfield Healthy
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The Promise of Youth

As director of the adolescent medicine program in the
Department of Pediatrics at Hennepin County Medical Center,
Julia Joseph-Di Caprio helps teenagers live up to their potential.

Di Caprio is a pretty good name to have these days if, like Julia Joseph-Di Caprio, M.D., M.P.H., your clients are crazy about Leonardo DiCaprio, the dashing young star of "Titanic."

Lately Joseph-Di Caprio has had to explain to at least one inquisitive teenage patient that she is not, alas, married to Leonardo.

Since October 1996 Joseph-Di Caprio, 35, has directed the adolescent medicine program in the Department of Pediatrics at Hennepin County Medical Center (HCMC) in Minneapolis. Her task is to develop a comprehensive, multidisciplinary program that will serve adolescents in Minnesota's largest and most culturally diverse county.

Building a program that helps cultivate the promise of young people is the vision that drives Joseph-Di Caprio. As a group, adolescents—11- to 21-year-olds—are physically healthy; the primary threats to their health stem from behaviors such as drinking and driving, violence, early and unprotected sex, and drug abuse. These behaviors can create acute problems, while other factors—tobacco use, poor nutrition, poverty, and sedentary lifestyle—can lead to long-term problems. Joseph-Di Caprio's goal is to provide clinical care while understanding and addressing the context in which young people live. That means assessing both risk and protective factors and fashioning appropriate interventions.

The HCMC program draws on expertise from

several fields. The staff includes six physicians, a nurse practitioner, a social worker, a nutritionist, a psychologist, four nurses, two clerks, and two medical assistants. Joseph-Di Caprio emphasizes that each person, from the clerk to the physician, is an integral part of the care team. Patients routinely see clerks, medical assistants, nurses, and physicians, and other team members are brought in as needed. If a young person expresses concern about gaining or losing weight, for example, the physician may call in the nutritionist.

HCMC's downtown clinic is currently available four afternoons a week and will add a fifth this month. "The need is such that we could go 24-7," Joseph-Di Caprio says. "Our hope is that this is a place where a kid can talk about things like starting to smoke, or if kids are smoking, to try to help them to quit," she explains. "Or if teenagers are considering having sex for the first time, we explore that with them and then help them to have sex in a safe way if that is their choice." Other issues they deal with include eating disorders and problems in school.

In addition to seeing patients at the downtown clinic, Joseph-Di Caprio and the other physicians visit youth at the Hennepin County Juvenile Detention Center, the Hennepin County Home School, St. Joseph's Home for Children, and clinics at four Minne-

By Cynthia Scott



PHOTOGRAPH BY JOHN NOLTNER

apolis high schools and one middle school. Joseph-Di Caprio serves as medical director at both the Juvenile Detention Center and the Hennepin County Home School.

The Joy of Teenagers

Joseph-Di Caprio and her husband, Fernando, have two children. Originally from Montreal, Quebec, the couple came to Minnesota in 1991 for Julia's pediatrics residency after she completed medical school at the University of Illinois in Champaign-Urbana. She completed her residency in 1994. Then, pregnant with her second child, she pursued a fellowship in

adolescent medicine at the University of Minnesota, under the mentorship of Robert Blum, M.D., and Gary Remafedi, M.D., pioneers in working with adolescents.

"The University of Minnesota Medical School has one of the premier programs in training adolescent medicine providers," she says. "The best part of the training experience was the master's degree in public health. I knew nothing about public health, but it was such an eye opener for me about the impact on adolescent health." She cites immunization as an example of an area that affects both the public health and individual health.

Not only have Joseph-Di Caprio's background and training prepared her to serve young people, but she also simply loves teenagers. In a world that often sees adolescents as a knot of thorny problems, she views them as vessels of pure promise.

"Adolescents are joyful and joy-filled," she says. "I've seen adolescents in the most dire of circumstances, where they might be perceived as having no future or little possibility of accomplishing anything, but they are still joy-filled. ... They may be troubled, they may have mental health problems, many engage in high-risk behaviors—sexually, drugs, violence, those types of things. But even with all of that, they are funny, they dress well, they are so much fun to talk with, they have so much going for them.

They're bright, they are interested in many things, and there's just an enormous amount of potential and possibility."

The Challenges of Adolescent Medicine

Adolescent medicine as a pediatric subspecialty is about three decades old. Joseph-Di Caprio believes it is burgeoning not because adolescents have more problems, but because health professionals and society in general better understand the distinct needs of adolescents. One of the most pressing needs is to connect young people with a primary care provider who will ensure access to preventive services, says Joseph-Di Caprio. Not all adolescents need a physi-

Family Practitioners



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The history...

Mork Clinic provides the people in Andover, Anoka, Blaine, Coon Rapids and Elk River the best possible health care available. The founder of Mork Clinic, Dr. Frank Mork, established the clinic in 1931, and in 1988, to keep pace with the ever growing communities,

the clinic expanded to Elk River. In 1997, the clinic merged with East Main Physicians, adding two additional sites, and is constructing a new clinic to be opened in Andover in April 1998. The practice now includes 38 physicians with nine Nurse Practitioners, five Physician assistants and over 280 support staff in a variety of specialties, including Family Practice, OB/GYN, Internal Medicine, Pediatrics, General Surgery, ENT, Gastroenterology, Rheumatology, Allergy and Orthopedics.

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Mork Clinic – Elk River

cian who specializes in adolescent medicine, she stresses, but all adolescents do need a primary provider. "The research tells us that is a wonderful way to help adolescents be healthier and improve their lives," she says.

Research by the Centers for Disease Control and Prevention and the National Institutes of Health shows that the incidence of risk behaviors, including smoking, alcohol abuse, and sexual activity, changes dramatically from year to year during adolescence. To be effective, primary prevention efforts require annual contact with adolescents, and yearly screenings are likely to identify teens who could benefit from early intervention.

Toward that end, Joseph-Di Caprio is developing a consult service within HCMC aimed at making staff in other departments aware of the services and expertise available in the adolescent medicine program. If, for example, an orthopedic surgeon learns that a young patient needs help coping with a violent home situation, the physician can use the adolescent medicine program as a resource in finding help for the patient.

Joseph-Di Caprio also hopes to develop methods for following up with youth who initially present in the emergency department. One way to do that, she says, would be to establish a program similar to one in Milwaukee that relies on a hospital-community partnership. The key to success in such a program is to identify youth who need additional resources and connect them with the appropriate community agencies.

One of Joseph-Di Caprio's chief areas of concern is incarcerated youth, such as those at the Hennepin County Juvenile Detention Center and the Hennepin County Home School. Advocacy organizations have established national recommendations for health care for incarcerated youth, but none are mandatory. Joseph-Di Caprio and other members of the Juvenile Justice Ad Hoc Committee of the Society for Adolescent Medicine are working to forge a position paper that would address this issue.

"Youth who are in corrections, like other youth, deserve good health care, but they are an underserved group," Joseph-Di Caprio says, noting that male adolescents are particularly vulnerable to falling through the cracks. Unless they have an acute problem, adolescent boys rarely visit a clinic, unlike girls, who come in for pregnancy testing or related issues.

Joseph-Di Caprio is nothing if not optimistic about the contributions she and her staff can make in the lives of youth. "If all you see are the problems, then you're going to think, 'Oh, man, those adolescents are doing all these bad things and they're terrible and we need to do this and that and the other thing.' But if you say, 'Wow, adolescents are great and they play such a great role in our world,' then we can see what can really be done to promote their health."

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Cynthia Scott is a Minneapolis writer and editor of the Minnesota Women's Press.

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Urban community medicine offers valuable and varied lessons.



By Chris Reif, M.D., M.P.H., Lynne Ogawa, M.D.,
Michele VanVranken, M.D., and Rebekah Tempest

Urban communities like St. Paul provide wide-ranging opportunities for physicians to understand and care for our patients. Because patterns of health and disease are woven from the dense fabric of an individual's physical, mental, environmental, and spiritual experiences, primary care providers must address the health needs of patients in the context of their family, their community, and their culture. The modern urban setting immerses physicians in the history of our clients' and

own shaman or curandera/o, and who still need their immunizations, diabetes education, and birth control.

High School Clinics

St. Paul is home to the longest-running school-based clinics in the country. HealthStart, a nonprofit organization, runs school-based clinics in each of St. Paul's six high schools and three alternative schools. These clinics were started in 1973 to bring health

in URBAN St. Paul



communities' past, engaging us as partners in finding a healthier future. The challenge for our residency programs is to combine the best knowledge, skills, and attitudes for teaching the art and science of healing in this setting.

In the Department of Family and Community Medicine at Regions Hospital in St. Paul, we explore many aspects of our community for opportunities to provide service and education. In concurrence with our mission—"to provide and teach high-quality family medicine in partnership with communities of need"—our staff and resident physicians practice at 19 different community sites representing the broad diversity that is St. Paul. Here's a sampling of some of the sites we visit and some of the lessons we have learned.

La Clinica

Also known as The West Side Clinic, La Clinica opened in 1972 to serve the unmet needs of the Hispanic residents of West St. Paul. Today, the cultural diversity of West St. Paul has greatly expanded and so has the clientele at La Clinica—now a tri-lingual clinic serving 40 percent Hispanic patients, 40 percent Hmong, and 20 percent native English speakers. We have six family practice residents at La Clinica who are learning how to become physicians for "New Americans"—for patients who often have no medical records, who may have their

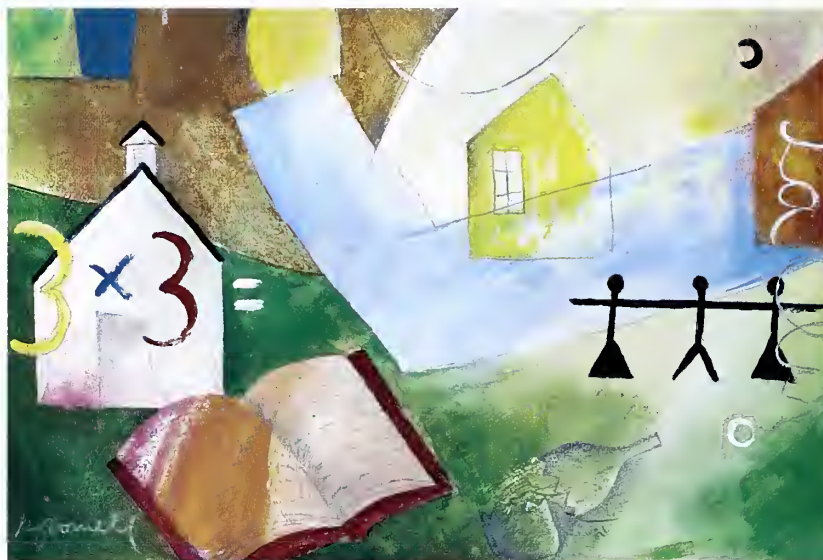
care to adolescents, especially those who might not have access to regular clinics and who might be exposed to increased health risks like early pregnancy and STDs. The underlying goal of these clinics is to improve students' health and chances for educational success. We see teens for depression, sprains, birth control, Hepatitis B immunization, family problems, positive Mantoux tests, eating disorders, sports physicals, and the like. The problems teens face today are a mix of well-known coming-of-age health risks, combined with the increasingly complex problems of the 1990s: HIV, drugs, violence, family breakup, depression, and recent relocation from other schools, cities, and countries. Yet, in the face of this complicated environment, we have seen adolescents become leaders in conflict resolution, HIV peer education, and co-parenting classes.

Senior Care

At the Edgerton Hi-Rise Apartments off Payne Avenue and at the Ramsey County Nursing Home on White Bear Avenue, we take care of seniors, many who've been the backbone of St. Paul's East Side. These men and women were born in the early part of this century and helped build the city's factories,

schools, neighborhoods, and families. They have stories about “the good old days” and opinions about “kids nowadays.” Now living in senior homes, they come to our clinic with aches, arthritis, rheumatism, gout, and more serious disease. Still vibrant, still involved with

in the morning, some preaching the gospel of AA. All needing medical care and all respecting us as physicians who have come to serve them. Common respect is the currency exchanged among these so poor in dollars. And as our residents provide good health care, they learn about despair and hope, family strife and family solidarity, and about living on a shoestring in a land of plenty.



their families and churches, they teach us about community and connectedness, disease and dying, loss and love.

The Homeless

Any cold night in Minnesota finds about 11,000 people living in shelters. More than half of them are women and children. Many are coming from other American cities like Chicago, St. Louis, and Detroit, where life has become harsh and dangerous. Like numerous immigrants before them, they are attracted to promises of a better life in the great city of St. Paul. At Family Shelter, we see many women and children at Wednesday's weekly clinic; mothers usher in kids with URIs, high lead levels, or asthma. Many are fleeing domestic violence and are seeking a new life for their children and themselves. A few blocks away, at the Union Gospel Mission off University Avenue, we staff a clinic every Tuesday morning for men who are “homeless,” although few of our clients accept this label. Some are “just passing through,” many are “down on their luck,” while others have “found a home” at the mission. Old men, young men; white, black, Hispanic men; some uneducated, some with college degrees; some smelling of beer at 7:30

Chemical Dependency

We go to ADAP, Twin Town, and Pride—three very different chemical dependency treatment centers in town. At all three, hope is sweated and prayed for one day at a time. Here, we see the recovery side of drug use and some balance to the ravages of cigarettes, alcohol, cocaine, and heroin too present in the hospital and on the streets of our community. Here, doctor and patient have the same goal and may reach across the chasms of race, class, opportunity, and sexual orientation to work together toward a better life and community for us all. Here, healing begins.

Corrections

We staff clinics twice a week at Ramsey County Jail and Workhouse, where we take care of diabetes and dermatitis, seizures and sinusitis, hepatitis and hypertension. We provide immunizations, HIV testing, help with chemical dependency, and education about safer sex. We give Mantoux tests and start too many people on INH prophylaxis. In brief, we provide basic health care to the citizens of St. Paul who have run into trouble with the law. Some of them are repeat criminals. Many of them will return to our neighborhoods and communities as moms and dads, brothers and sisters, with another chance to build a better life. Sadly, some of these people have better access to health care in jail than they have in our community.

Safe Zone

Late on Tuesday afternoon we go to Safe Zone, the teen drop-in center in downtown St. Paul run by Face to Face Clinic. Here we see teens who live a good deal of time on the street. We offer examinations and some medicines. Mostly, we talk to them about their families, moods, girlfriends, boyfriends, weight problems, skin problems, sex, smoking. ... At 7 p.m. we close the doors and go home while the teens return to the streets.

Our Lessons

Our practice and teaching at different sites in St. Paul offer several clear lessons about urban medicine. First, our city is composed of many cultures. To meet health needs, physicians must be culturally aware. Second, improving health in an urban setting is a team effort; we work in networks, collaborating with nurses, teachers, police, and social workers. Third, prevention is important for improving individual and community health, and it takes many forms—distributing condoms to the sexually active and clean needles to IV drug users, ridding neighborhoods of guns, and improving reading skills among those who can't make out the labels on their medications. Fourth, people's health reflects their environment. Where there is smoke and pollution, people cough and have asthma; where there are parks and

rec centers, neighbors gather and kids play games; where there are guns and poverty, people do drugs and get shot. Finally, and most important, while there are fundamental similarities among people and disease wherever you find them, there are also profound differences based on family, culture, and community. Our challenge as physicians is to recognize and appreciate the similarities and the differences among the patients and communities we serve.

MM

The authors are from the Family Medicine Residency Program of Regions Hospital. Chris Reif is director of Community Medicine and a faculty physician. Lynne Ogawa and Michele VanVranken are third-year residents and will remain another year as community medicine fellows. Rebekah Tempest works in technical communications.



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HCMC *Reaches Out* from the INNER CITY

Hennepin County Medical Center is committed to serving a wide diversity of patients, whether they're in the neighborhood or not.

Lowell Stoltzfus, M.D., rides his bike or walks the 10 blocks from his Bryn Mawr home each day to work at the Glenwood-Lyndale Community Clinic at 503 Bryant Avenue North in Minneapolis. On the way, he might wave hello or stop to chat with one of his patients he passes on the street. Stoltzfus's proximity to the clinic, where he is the lead physician, makes him a member of the community, not just a visitor.

Like many of his colleagues at Hennepin County Medical Center, which runs the Glenwood-Lyndale clinic, Stoltzfus is committed to providing medical care for underserved patients. By living in North Minneapolis, he says, he can offer a level of service that would be hard to achieve in a suburban setting.

JEREMIAH CHRISTOPHER WHITTEN

PHOTOGRAPH BY ROB LEVINE



"I'll see extra patients or walk-ins, or I'll do home visits for elderly people," Stoltzfus says. "I'll advocate for my patients and end up doing certain aspects of social work for them that many other doctors would be unable to do."

A memorable example of this kind of care involved one of Stoltzfus's first patients. A few weeks after the Glenwood-Lyndale clinic opened in November 1995, a Hmong couple brought in their 3-month-old child. The baby's head was enlarged and she was vomiting. After she was sent downtown for tests, she was diagnosed with an inoperable brain tumor. The parents, who spoke little English and were confused and intimidated by the Western medical system, took their daughter home to die. Stoltzfus visited the family at their house a few nights a week to comfort the parents and their children. The baby died about two months later. The other family members continue to receive health care at the clinic and remain close to Stoltzfus.

Despite the long hours and emotional intensity of practicing medicine at an inner-city clinic, Stoltzfus loves his work. "I can see myself doing this for the rest of my career," he says. "It comes down to my Christian faith that this is where I should be working."

Reaching Patients Where They Live

Stoltzfus's dedication to seeing patients on their terms and their turf is echoed by many Hennepin County Medical Center doctors who strive to meet the needs of their widely diverse patients. Physicians and administrators at Minnesota's largest public hospital repeatedly bring up the same point: access to care is the most important service HCMC provides. And it isn't enough to have one central location. According to Doug Hanson, HCMC customer relations director, you have to go into the neighborhoods and establish clinics to reach people who can't reach you.

That approach, and its success at the Glenwood-Lyndale Community Clinic, recently earned HCMC a prestigious NOVA Award, presented annually by the American Hospital Association to five U.S. hospitals that have demonstrated commitment to their communi-

ties (see the sidebar, page 16).

"If you look at the underserved populations in Hennepin County, a profile quickly emerges," says Hanson. "It runs north and south from Brooklyn Center, to North Minneapolis, to downtown, to South Minneapolis, and out to Richfield and Bloomington. We have tried to design our clinics to follow the population of need."

HCMC operates satellite clinics in Brooklyn Center (Hennepin County North), South Minneapolis (Family Medical Center and Elder Care), and Richfield (Hennepin Care South), and it works with other agencies to run the Glenwood-Lyndale Community Clinic. The hospital also provides medical services to 21 non-HCMC clinics throughout Hennepin County and to six public schools.

Why go to the extra expense to establish neighborhood clinics when the main hospital is just a few miles away? Because three or four miles can seem like another



PHOTOGRAPH BY ROB LEVINE

An interpreter (center) translates during Dr. Lowell Stoltzfus's consultation with a family at the Glenwood-Lyndale Community Clinic in North Minneapolis.

world to people with no cars, no money for the bus, and no daycare for their children.

"When I began this practice, I thought it was an unnecessary expense to have a clinic so close to the hospital," says Joe Sierra, M.D., a physician with the Family Medical Center and medical director of the Hennepin County Health Care for the Homeless Project. "But then I realized that if we were going to reach the patients and the pathology, we had to reach them on their

own terms. The world from our clinic on Fifth and Lake Street is completely different from downtown. We could leave our patients alone in the neighborhoods, let them get sick, and then go pick them up, but that would just be more costly in the long run. They have a comfort level at our clinic. They have a relationship with us."

Cultural Diversity Is the Norm

From 1990 to 1996, the total population in Minnesota increased by 6.2 percent. Looking at population growth by ethnic group reveals the changing demographics: the number of people of Asian and Pacific Island heritage grew by 40.7 percent; Hispanics increased by 40 percent; African Americans grew by

From Gang Battleground to Community Health Clinic

For years, the near north side of Minneapolis was predominantly a black neighborhood, a place where folks knew each other and felt at home. But the shifting demographics that affected Minnesota as a whole were especially pronounced in the Glenwood-Lyndale community, where the ethnic mix changed quickly and dramatically. By 1992, Southeast Asians made up 42 percent of the neighborhood, African Americans 32 percent, and whites 21 percent.

The Glenwood-Lyndale Community Center became a battleground for rival Asian and black youth

wood-Lyndale Community Center. Akale organized a series of neighborhood meetings with residents from different cultures. "The purpose of the meetings was twofold," Akale says. "We wanted to ask residents how the community center could better serve them, and we wanted persons from different ethnic groups to begin a dialogue with each other."

The dialogue began, sometimes over meals prepared by women from different cultures, and gradually a spirit of cooperation emerged. One need residents emphatically identified was accessible, respectful health care services. Akale and his staff

moved quickly to get funding to develop the Glenwood-Lyndale Community Clinic in partnership with several county, city, and community agencies. With the Glenwood-Lyndale Community Center and Hennepin County Medical Center as lead agencies, the clinic opened in November 1995. In 1997 more than 7,000 patients visited the clinic. Fifty-four percent of patients are Asian American, 12 percent African American, 14 percent Somali/Sudanese, and 2 percent Caucasian.

The clinic has been judged a success not only by staff and patients but by the American Hospital Association, which awarded HCMC a 1998 NOVA Award for the hospital's role in the collaboration. The award was presented to HCMC officials at the AHA's annual meeting in Washington, D.C., in February.

The NOVA Award is given annually to five hospitals in the United States that have demonstrated commitment to their communities "by stepping outside their usual bounds to serve the greater good, driven by broader visions of what it means to provide health care," according to the AHA.



Southeast Asian dancers perform at the grand opening of the Glenwood-Lyndale Community Clinic.

gangs. Intimidated residents stayed away from the community center for fear of being caught on the wrong side of a fight.

The climate changed in 1994 with the arrival of Christian Akale, executive director of the Glen-

32.5 percent; “other” minorities, including the recent influx of Russians and Somalis, also grew by 32.5 percent. Meanwhile, Minnesota’s white population grew by just 4.8 percent.

Nowhere is Minnesota’s cultural shift more evident than in its core cities. Hennepin County, with 23 percent of the state’s total population, is home to 42 percent of its minority residents. Part of Hennepin County Medical Center’s mission is to meet the medical needs of these diverse, and often poor, inner-city residents.

HCMC Administrator John Bluford has seen hundreds of examples of his staff adapting to patients from non-Western cultures in his 20 years at Hennepin County Medical Center. In a hospital where 56 percent of the patients are nonwhite, cultural diversity has become the norm.

Yet one incident stands out as a defining moment. It happened early in Bluford’s tenure at HCMC, one day when a nurse walked into a room and interrupted a healing ceremony for a Native American patient. Part of the ceremony involved burning sage, which the nurse suspected was marijuana. The nurse called hospital security officers, who seized the sacred objects used in the ceremony. The incident quickly escalated into a volatile and emotional confrontation. To help resolve the situation, HCMC officials met with members of the Native American community to gain a greater understanding of their cultural practices. One result is that Native American ceremonies are now commonplace in the hospital.

“That was one of our first cultural adaptations, and it was an easy fix. We accommodate those kinds of things all the time now,” Bluford says, adding that HCMC is currently looking for prayer spaces for Muslim patients who need to pray three times a day. Bluford also mentions the 50 full-time, part-time, and free-lance interpreters the hospital employs to translate 35 different languages for the hospital’s large immigrant patient population. (In 1997 HCMC received about 54,000 requests for interpreter services, a 25 percent increase from the previous year.)

Bluford realizes that not all hospitals can embrace cultural diversity so easily—especially smaller hospi-



Some North American Indian tribes pray and burn sage, cedar, or sweet grass daily to purify mind, body, and spirit.

tals. “If you only have one Native American patient encounter per year, then it becomes very difficult,” he says. “But if you have hundreds every day, then you look at it differently. These are our patients, and we have to meet their needs.”

Appealing to Two Patient Bases

In addition to serving poor, inner-city residents, HCMC tries to appeal to more affluent patients and to those outside the city’s inner ring by emphasizing what Bluford refers to as the “soft amenities,” along with state-of-the-art medical care and research not usually found at public hospitals.

“We don’t have any problems taking care of a wide range of patients, from homeless people to executives who have heart attacks while they’re working downtown,” says Tim Crimmins, M.D., an emer-

PHOTOGRAPHS BY NANCY LEE GARD, HENNEPIN COUNTY MEDICAL CENTER

gency medicine physician and deputy medical director of HCMC. "We are here to serve the underserved and to provide highly technical medical services to anyone who needs them."

The newly remodeled Newborn Intensive Care Unit

very young and don't appreciate the need for prenatal care. And then there are families that are non-English speaking or are unfamiliar with Western medicine and don't even know what prenatal care is."

The newborn intensive care unit serves a large immigrant population of Somalis, Russians, and others. Benson says her staff go out of their way to meet patients' diverse needs. "We make any adjustments and accommodations that we are aware of. ... We don't try to Westernize [the patients]."

Cultural adaptations include assisting Hmong women who prefer not to labor in bed but instead squat on the floor when delivering their babies. Many Hmong women do not hold their babies immediately after giving birth—they follow the tradition of having the father bathe the child before returning it to the mother.

In an effort to broaden the appeal of the remodeled NBICU, many comforts were added, including three live-in rooms for parents, a sibling playroom, a mother's room for nursing, a library, and a laundry room to ensure that the infants' tiny outfits will be handled with care.

HCMC's newborn intensive care unit, along with its respected nurse-midwife program, led *Self* mag-

azine to name Hennepin County Medical Center one of "America's 10 Best Hospitals When You're Having a Baby." Yet, despite the ranking, few suburban mothers in Hennepin County think of HCMC when choosing where to deliver their babies.

Perception Versus Reality

HCMC's logo proudly announces its status as a "Level I Trauma Center." Indeed, the hospital was the first Level I trauma center in Minnesota. But some physicians worry that emphasizing the hospital as a trauma center scares off suburban patients who might otherwise choose HCMC for elective care.

Deputy medical director Tim Crimmins speaks candidly about how patients choose where to go for health care: "If you're critically injured, you'll go to Hennepin. If you're doing elective surgery, you'll go where you're comfortable."

Neonatologist Richard Lussky, M.D., wants to spread the word about the many other highly regarded programs the hospital offers. "I had a meeting with the managing



Getting some shuteye in HCMC's Newborn Intensive Care Unit.

(NBICU) is a prime example of a state-of-the-art facility that fulfills HCMC's mission to serve the public while also appealing to fee-paying patients with private medical insurance. The NBICU has 21 infant beds: 12 level-three (critical) beds, eight level-two beds, and one isolation bed. Since loud sounds and bright lights can adversely affect premature, underweight infants, the unit contains sound-absorbing ceiling tiles, and each bed has individualized lighting. Space nearly tripled to 250 square feet per patient. Besides these technological improvements, stars glitter from the ceiling, clouds float on the walls, and natural light shines in from windows on one side.

Nursing supervisor Connie Benson, R.N., says that 20 percent of all babies delivered at HCMC end up in the NBICU. Most are premature, due to high-risk pregnancies, lack of prenatal care, the mothers' drug use or infections, or birth anomalies. Some infants stay in the unit for up to 18 months. Patients in the NBICU tend to reflect the stresses of inner-city life, Benson says. "Socioeconomics factor into the causes of prematurity. Moms need prenatal care and services. A lot of our families are

partner of one of the biggest law firms in the Twin Cities, and one of his colleagues said to me, 'I wasn't aware that you do deliveries [at HCMC].'

"We're very proud of our Level I trauma status, but we want suburban mothers to feel comfortable enough here to have their babies," says Lussky, assistant medical director of the NBICU. "There's a downside to always talking trauma when you want to get more OB patients in here. Part of it is that it's the media's image also. When there's a piece about violent gangs and they go to the medical center, it just perpetuates that image."

Such perceptions hinder HCMC's recruitment efforts, says Patricia Cole, M.D., director of the hospital's family practice residency program. "I've had medical students ask me how safe it is to work at Hennepin County," she says. "The gunshot wounds get all the publicity. The media delights in making catastrophes out of everything. But that distorts the work we do."

If people can get past those images, Cole says, they frequently are impressed with HCMC. "We had a med-

ical resident from Montana who was assigned here, and she was very apprehensive because she wanted a rural practice. She has been absolutely thrilled with it here. In fact, she stayed on to become a member of the faculty."

Lussky agrees that many people, especially those from outside the state, are pleasantly surprised by Hennepin County Medical Center. "When I came here to do my interview, they had to convince me that this was a public hospital," Lussky recalls. "I thought it was private. There were literally rats and cockroaches when I was at [Chicago's] Cook County Hospital. HCMC is a gorgeous facility, which is reflective of the collective pride that the state of Minnesota has in it. The patients have pride also. The community ownership of this hospital is something I never felt at Cook County."

Involving Patients in Their Health Care

Playing to its strengths, Hennepin County Medical Center promotes its role in urban medicine. In 1994 Patricia Cole developed a special rotation for medical residents at



Upon admission, all pediatric patients at HCMC are given a stuffed animal, which staff use to explain to the kids what will be done to them.

PHOTOGRAPHS BY NANCY LEECARD, HENNEPIN COUNTY MEDICAL CENTER

the University of Minnesota. Students in the Urban Community Ambulatory Medicine program participate in a four-month primary care rotation based out of neighborhood clinics, such as HCMC's Family Medical Center, that serve low-income and homeless patients.

Cole says she hopes the experience of working in Minneapolis's poorest neighborhoods will change the way medical students think about practicing medicine. "My hope is that students who are exposed in a profound way to people of other cultures will meet those people differently—that they will understand that the rational, orderly, Western approaches that may work for middle-class patients don't necessarily fit with folks who are closer to their indigenous cultures, where relationships and spiritual issues and community values are more important than what an expert has to say about health care. I want them to engage patients as partners in the process of healing, and that takes a different kind of training than maybe we've used in the past."

Community relations director Doug Hanson also stresses the importance of seeing patients as partners, not as victims or statistics. "Don't look at people as having diseases and problems," he says. "Look at them as having innate health. It sounds obvious, but it's a hard

thing to deliver when you're a trained professional used to focusing on pathology or problems. Many of these people are refugees and have suffered persecution. It is important to affirm to them that they still have the ability to be healthy."

Christian Akale, director of the Glenwood-Lyndale Community Center, agrees that communities need to be involved in their own health care. "We know that our area where the Glenwood-Lyndale Community Clinic is located has ranked abysmally in all health indicators," he says. "What that tells us is there is still work to be done. We need to focus on prevention. We need to continue to integrate the community into thinking about primary care, so we can avoid a relapse into diseases that are curable but which still persist."

Both the community center and clinic follow the Health Realization Model, which emphasizes health over pathology and stresses the need to treat people with dignity and respect. Clinic staff deal with every patient in a way that respects the individual's intelligence and innate health. With this model, Akale says, the scope of the clinic's vision moves beyond individual well-being to community well-being, a goal that ties in well with HCMC's overall mission.

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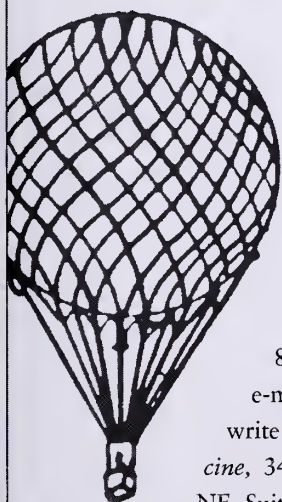


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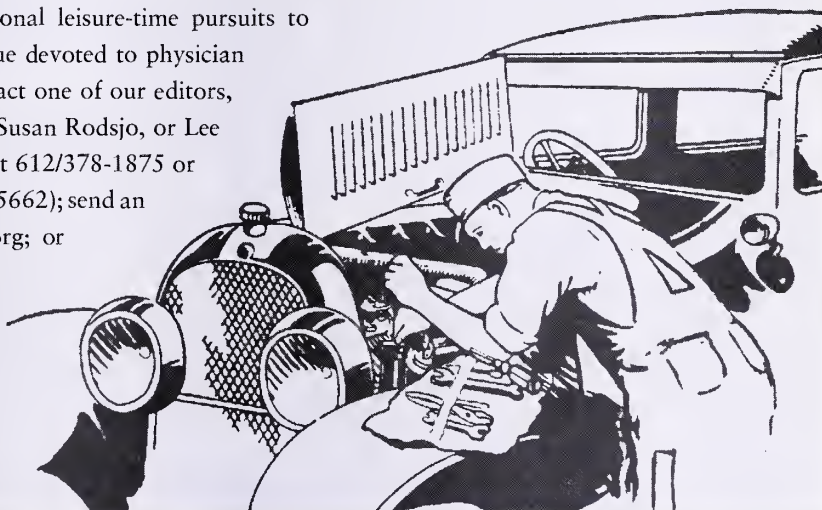
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EMERGENCY DOCS in Their Element



Emergency physicians thrive on the adrenaline-fueled pace of their work, but the stress adds up—in EDs inside and outside the city's core.

Text by Douglas Clement
Photographs by Andy King

It's a little before midnight in the emergency department at North Memorial Medical Center. A 75-year-old man has ruptured a blood vessel in his left eye, and Gail Joyce, M.D., a second-year emergency physician at North, is examining his cornea through a slit lamp.

"Are you an eye doctor?" asks the man, staring straight ahead.

"No," Joyce says. "I'm an ER doctor."

The patient is confused. "What's that?"

"Well," replies the physician, smiling but not hesitating. "That's who you see when you come to the emergency room."

What is an emergency physician?

Joyce's answer was accurate and expedient—but not the whole story. After all, emergency room—or department—docs are the master jugglers of the medical world: the frontline trauma surgeons, the 24-hour-a-day cardiologists, the first-call comforters of parents with febrile babies. These are the physicians we rely on to handle our most urgent and disquieting medical crises. They're romanticized by television, targeted by cost-cutters, and attacked by angry patients. And through it all, they remain an enigma.

Part of the puzzle lies in the field's dramatic transition over the past 30 years. Before 1968, emergency medicine in the United States was more of a career hiatus than a medical specialty. "The stereotype used to be that the emergency physician was an old retired guy who covered the emergency department," notes Bruce Adams, M.D., vice president of medical affairs at North Memorial and an ED staff physician there from 1986 to 1995. "And for a long time, one of the criteria to be on an awful lot of medical staffs was that you had to take your turn in the emergency department. So you could go into an emergency department and one night see the cardiologist and the next night see the dermatologist."

Historically, emergency departments were often staffed by physicians disenchanted with their previous practice or unable to find employment elsewhere. "Unlicensed interns, foreign graduates without credentials, and non-ER-oriented physicians on rotating call schedules soon stigmatized the ER as a risky place to go, a place where a woman might reluctantly have her baby delivered by an equally reluctant ophthalmologist," wrote Reinald Leidelmeyer, M.D., one of the first physicians to propose the idea of full-time emergency physicians.

As the use of emergency departments climbed nearly fourfold between 1955 and 1971, hospitals and physicians struggled to improve staffing practices. Hospitals in Virginia and Michigan were the first to create full-time emergency department staffs during the 1960s, and in 1968 eight ER doctors formed the American College of Emergency Physicians (ACEP). Two years later, the first emergency medicine residency program was established, at the University of Cincinnati, and in 1979 the American Board of Medical Specialties officially recognized



emergency medicine as a specialty. Certification exams began a year later. ACEP has grown from eight to nearly 20,000 members who work in about 5,000 emergency departments across the country.



Ernest Ruiz, M.D., was Minnesota's emergency medicine pioneer. Trained as a surgeon at Hennepin County Medical Center, Ruiz was asked in 1971 to direct the newly created HCMC Emergency Department. "After I'd been doing it for a few months, I realized that it needed to be a specialty of its own and we needed to start a residency," recalls Ruiz, now director of the emergency medicine program at the University of Minnesota Medical School. "So, in 1972, I started what was probably the second or third emergency medicine residency in the United States."

At 67, Ruiz is beginning to ponder retirement, but his enthusiasm for the specialty he helped to create remains unquenched. "I've been in it for over 30 years, and I still think it's fun," he says. "I'm not burned out at all. Most emergency physicians gripe a lot about it, but most of them wouldn't do anything else."

Indeed, the charged atmosphere of the emergency

department seems to exert an almost gravitational force over emergency physicians. "It seemed like no matter what rotation I was on," recalls Gail Joyce of her medical school training, "I'd end up going down to the ER, either to pick up patients or to see the trauma patients. ... It was always going, always moving. And I liked that."

Joseph Horozaniecki, M.D., a 24-year veteran of Fairview-Southdale's Emergency Department, comments on the same phenomenon. "Unique to all emergency doctors is their love of the ER environment—the ambiance, the ebb and flow of what happens here," he observes. "There's a certain amount of background noise and chaos that's going on all the time and I think we all kind of love that. The pace of the work also draws us. The urgency of situations. Some of us constitutionally enjoy working at that heightened level of excitement."

In an emergency department, the workflow is unpredictable, the caseload unknowable even an hour in advance. A day can be peaceful or out of control, hinging, for example, on a bus-car accident or a drug buy gone bad. That very uncertainty and intensity is what draws many physicians to the field. "The term 'adrenaline junkie' comes to mind," says Bruce Adams. "And it's been used accurately for those people who tend to go into emergency medicine as they're in the younger portion of their careers."

Jim Thompson, M.D., medical director of the Fairview-University Medical Center Emergency Department, agrees. "A lot of emergency physicians like that—being stretched, seeing things unfold, and dealing with catastrophes. It's an action-oriented specialty. You want quick evaluations, quick actions, good quick results."

Gail Joyce also likes the pace, she admits during a break in the action. The clock reads 1:09 a.m. "But the key is being cool when that is happening," she says. "There are times when it gets quite nerve-racking here, and you're working fast and you're working hard and you know more is coming." She pauses. "Trying to keep your cool and keep your sense of humor is really, really, really important."

And that is precisely the problem. How does one maintain composure, perspective, and even compe-

tence when faced daily with an unpredictable and demanding stream of both mundane and life-threatening illnesses? The pace of an ED may be invigorating in the short term, but over the long run, the psychological stress can contribute to burnout among emergency physicians.

"Probably the hardest part of the job is dealing with the cumulative stress that's produced by working in the emergency department," says Thomas Stewart, M.D., chief of emergency services at Fairview-Ridges Hospital and president of the Minnesota chapter of ACEP. "Dealing with psychologically traumatizing situations on an acute and chronic basis is the most difficult part of the job."

Timothy Crimmins, M.D., deputy medical director at Hennepin County Medical Center, understands that difficulty all too well. "As I've gotten older, I've had more trouble dealing with the critical care cases," says Crimmins, 43, who works half time in the emergency department on top of his administrative duties. "When you're younger, they seem like what we used to call 'great cases' because of the difficulty and the criticality, and the ability to save lives. But as you get older, the situations seem to become more personalized for me, and I recognize that these—what used to be 'great' clinical cases—represent personal tragedies to all of these people and their families."

While there are no well-defined systems for coping with such stress, Thomas Stewart suggests that emergency physicians could learn from the paramedic community. "They have critical stress debriefing [sessions]; I think that emergency medicine should be looking at that sort of thing."

The problem is most acute for urban emergency physicians, due in part to the heavy workload. "If you're working out in some of the more rural hospitals, there'll be significant periods of downtime," observes Bob Knopp, M.D., emergency physician and director of education at Regions Hospital. "But if you're working in an urban hospital emergency department, there's going to be very little time when you're not seeing patients."

Moreover, the types of medical problems vary significantly between urban emergency departments and rural or suburban hospitals. "[At] inner-city emergency departments, you get much more a taste of society's ills, if you will," says Doug Brunette, M.D.,

an HCMC emergency physician since 1985. "Firearm violence is just one of the things that we see a lot of, but you will definitely see much more penetrating trauma than I think you would see at outlying places, and because Hennepin is a referral center ... also probably more than our fair share of blunt trauma."

As Brunette suggests, urban emergency physicians deal with a poorer patient population, and their EDs become primary care clinics, the doors to hospitals and clinical assistance. "Inner-city emergency departments are sort of the safety net for what's wrong," says Brunette. "We see the homeless and we see the victims of poverty, so oftentimes we're dealing not only with a medical issue but also social and economic issues."

It's a challenge to care for patients who need so much, and not every doctor enjoys it. "There are many people who trained at Hennepin who can't wait to get the hell out of Dodge, quite frankly, because they want to practice at Southdale or wherever," Brunette says. But urban physicians like Brunette find the urban setting more rewarding. "You know, when you get a thank-you from somebody who is a homeless person, versus a thank-you from someone who is well-to-do, I don't know, given a choice, I think I'd take the one from a homeless person."

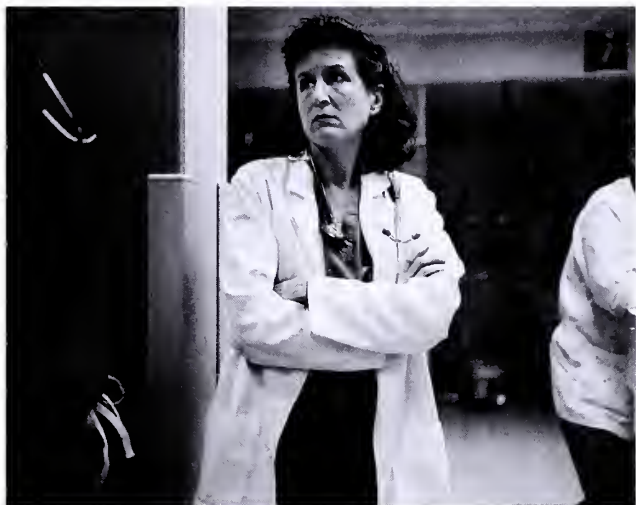


"There are times when it gets quite nerve-racking here, and you're working fast and you're working hard and you know more is coming. Trying to keep your cool and keep your sense of humor is really important."

—Gail Joyce, M.D.

Regardless of setting or patient population, all emergency physicians find another major source of stress in shift work, the battle against circadian rhythms. "This place is open 24 hours a day," says Thomas Timmons, M.D., medical director of North Memorial's emergency department. "And what you can do at age 30 isn't the same as what you can do at age 50, in terms of working days, nights, and evenings and rotating around the clock."

The challenge should be met head-on, argues Timmons. "We've done things here to be more active in residency programs, which improves your longev-



ity in the practice," he says. Residents provide not only physical assistance but also bring a liveliness and sense of curiosity—with their many stimulating questions—to an ED, which gives physicians a less tangible but equally valuable boost.

Timmons mentions other ways to meet the challenge: "We've always been double-covered on night shifts, recognizing the extra demands that nights place on people over the years. And many places are letting aging physicians take more time off, get involved in administrative activities, and cut down on their clinical time, and that has helped."

Fairview-University's Thompson expresses similar ideas: "When the first emergency physicians were finishing their residencies, they'd say ... 40 hours a week shouldn't be a problem. Well, it turns out that that's not even beginning to be practical." Thompson's medical group has reduced expectations for working hours, cut night shifts to as few hours as possible, and encouraged physicians to establish regular patterns of sleep and exercise.

Beyond that, says Thompson, ED docs tend to burn out when they lose contact with other priorities, such as families, friends, and recreation. "So we encourage people to make those things important in their lives," he says, "to get the proper balance between their practice and their life."

For some physicians, creating the right balance means leaving emergency medicine. After 24 years in the ED, Joe Horozaniecki, 55, is quitting emergency medicine when his contract expires in July. "I certainly will miss the ambiance here, but you get to a certain age and it gets really, really difficult to work at three o'clock in the morning," he says. "At my age, I feel the need now to spend more time with my family."

Many of these issues don't loom large for Gail Joyce. She doesn't plan to have children, and Dunn Brothers coffee helps her through the wee hours. She does have other concerns, though. This night has been calm so far at North Memorial: a girl who slipped on ice, a feverish baby, a woman who sliced her toe by kicking a refrigerator, a young man with a gashed lip.

But more traumatic cases can elicit angry reactions from patients and family members. "It's not something I worry about on a daily basis, but I think it's just a matter of time before somebody [on staff] does get hurt," Joyce says. "People get mad a

lot. They get mad if they have to wait. They get mad if somebody they care about dies. They get mad when some other gang shot at them. ... And you're always afraid that they're going to take it out on you." Though she and other staff take precautions, the worry persists.

Her biggest fear, however, is of making a mistake. "I fear that I'm going to make the wrong decision, fear that I'm going to let somebody go home and shouldn't," she says. "There are often times when I'll go home at night and I can't get to sleep because my mind is on one particular patient that I sent home. With the volume in the ER as it is, and the number of patients that we see, there's always the chance that you're going to miss something."

Still, despite the hours, the stress, and the fears, Joyce is clearly in her element in the ED. At 2:24 a.m., she and her night-shift colleague, Paul Brunik, M.D., are drinking more coffee and swapping advice. A medical technician walks up and tells Joyce that he's finished prepping the 50-year-old woman who arrived an hour ago with a cockroach in her ear. "You can see it a bit better now," says the tech. "I irrigated it a lot."

"OK," says Joyce, setting down her cup. "Let's go see if we can get it out." She jumps up, primed like an athlete, her white Nikes in swift motion toward the patient's cubicle. "The pressure's on," she jokes to a reporter who plans to watch the roachectomy. "I love it."

MM

Douglas Clement is a free-lance writer in Minneapolis.

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G is for Gangsta

Understanding Gangs in Minnesota

Gangs are no longer just an inner-city problem in Minnesota. A counselor and a police officer have teamed up to understand gang members and help them find a way out of gang life.

The old African proverb says, "It takes a whole village to raise a child." In modern America, where the village too often fails, street gangs succeed—filling the vacuum in young people's lives as protector, big brother, parent, teacher, mentor, colleague, friend, and lover. Kate Cavett, M.A., and John Harrington, M.A., are trying to help the village we call Minnesota reclaim youth lost to street gangs.

Cavett, a chemical dependency counselor, and Harrington, a lieutenant with the St. Paul Police Department, in May 1996 formed the nonprofit organization Hand In Hand to study street gangs in Minnesota. With grants from the state Legislature,* Honeywell, General Mills, and the Minneapolis Foundation, Hand In Hand began working with gang members to better understand the gang culture, why kids join gangs, and how to combat the violence and destruction they cause.

Cavett became interested in gangs while working as a chemical dependency counselor. Gang members told her their stories, which she recorded and transcribed. As Cavett looked for more information, she was frustrated by the lack of available tools to help kids leave gangs. Often, professionals simply suggested that young men or women should resign from a gang, the way one would resign from a job.

That response showed little awareness of the bond gangsters feel to their world, Cavett says. Imagine suggesting to someone that he quit a job that pays \$150 an hour and take the only job for which he is qualified—one that pays the minimum wage. Likewise, Cavett says, you wouldn't tell someone to quit a job if you knew that leaving meant a thorough beating or even death.

When Cavett showed Harrington the kids' stories, they confirmed what he had heard while serving as school liaison director for the St. Paul schools and later heading the St. Paul Police Department's Juvenile Unit. Harrington, who is also an assistant professor at Metro State University, looked for more information about gangs but found only outdated, highly academic, theoretical models of gangs, which did not accurately describe the Midwestern gangster.

Harrington and Cavett teamed up to form Hand In Hand. Their mission is to develop, through applied research, a deep understanding of youth gangs; to educate professionals and the community about gangs; and to create effective interventions and programs to support young people who want to leave the gang culture.

The two have interviewed 40 gang members, with a goal of interviewing at least 200. Each interview is a process of first gaining trust and understanding, then recording stories.

*Initial funding was appropriated through the Minnesota Department of Public Safety during the 1997 legislative session.

By Matt Loskota

Cavett often spends 20 hours or more with an individual. She says these are “troubled kids, not demons.”

Midwestern Gangs

Through their interviews, Cavett and Harrington are dispelling long-held myths about street gangs, including the ideas that gangs operate only in the inner city; gang members are poor; girls don't join gangs; and youth join gangs for drugs and money.

In the Midwest, we all live closer than we think to a growing gang problem. In addition to aggressive gang activity in the inner city, gangs are found in every corner of the metropolitan area, including Bloomington, Cottage Grove, and Edina; gangs also do business in Albert Lea, Duluth, Grand Rapids, International Falls, Mankato, St. Cloud, Rochester, Willmar, and Worthington. Of the estimated 10,000 gang members in Minnesota, less than half operate in the core cities of Minneapolis and St. Paul.

Girls and young women are active gang participants, “beat in” like the guys or “sexed in” to the life. Female-only gang subsets, such as SOS, Sisters of the Struggle, are as violent as their male counterparts.

Children as young as 8 years old claim gang affiliation. A third-grade teacher in Minnesota recently reported that a student threatened classmates with drive-by shootings.

In Minnesota, authorities have identified over 100 different gangs or gang subsets. The majority of these are imports from other parts of the country and have developed their own cultures. In 1982, the Chicago gangs Gangster Disciples, El Rukins, and Vice Lords arrived in Minnesota when Chicago authorities transferred convicted criminals from their overflowing prisons to other cities' correctional facilities. These gangs use a militaristic hierarchy and are organized like corporate franchises. At least 30 varieties of the GD and Vice Lord franchises exist in Minnesota.

Los Angeles-based gangs soon followed, bringing Crips and Bloods. Minnesota has about 35 “sets” claim-

“We just used to kick it, you know ... fight in the basement, box, ... smoke chronic, shoot cats, you know. That was just a normal day, kicking it day. Almost getting shot ... always had a smile on our face, even though, you know, we just got shot at. But still smiling, we got away. The playpen was the concrete jungle that we played in.”

—The Poet, 18-year-old
black American
MO Family Gangster,
St. Louis, Missouri

ing one of these affiliations. L.A. gangs are organized on a flat model, with no clear leadership. An 8 Tray Gangster (Crip) described why these gangs are hard to fight: “You can't kill nothin' that doesn't have a head.”

While Chicago and L.A. namesake gangs are stereotypically black, Minnesota is also home to Native American, Hispanic, Asian, white supremacy, motorcycle, and independent gangs. Gangs have become “Minnesota nice,” says Harrington about the cultural diversity of gangs. Any “set” may include several races. Outstate organizations, however, are predominantly white.

Although skin color doesn't matter as much in Minnesota, gang colors do. Black, red, blue, and gold are the

most common colors. Aspiring and hardcore gangsters “flag” themselves with bandanas to declare their affiliation. If you walk into Gangster Disciple territory, which is the color blue worn on the right, and you're wearing red on your left side, you're asking for trouble. Often one color is predominantly worn for fun, another for official gang business.

Gangs are becoming high-tech. Try surfing a gang Web site, such as www.unitedinpeace.org. In addition to traditional communication methods such as graffiti, gang members use laptops and mini-computer/organizations like the Newton, with infrared information transfers.

Why Do Kids Join Gangs?

Most of us probably think that kids join gangs to get money and drugs. At a recent Youth and Gang Violence Prevention Workshop, Hand In Hand let the kids themselves tell attendees why they joined gangs. The audience sat transfixed, watching the young faces flash up on screen as these “gangsters” explained in taped interviews the appeal of gangs, using words like power, respect, love, protection, guns, glamour.

Harrington and Cavett use William Glasser's “control theory” to analyze the attraction and sustaining influence of gangs and gang life. Glasser highlights five

basic human emotional needs: security, love, power, freedom, and fun.

The physical protection gangs offer kids who live in bad neighborhoods is often worth the beating required to join. Gangs also offer a deeper security—a safe emotional environment. Amid his chaotic, criminal life, the hard core gangster finds security knowing his back is always covered.

Another of Glasser's described needs, love, helps gangsters deal with their hostile world. Time and again, the interviews reveal a common theme of

involved in gangs give power. Teachers too scared to wake sleeping students give power. Schools that overlook gang activity give power. Suburban communities that deny a growing gang problem give power.

With power comes freedom, the next need in Glasser's model. Security in numbers, unconditional love, and the power of fear give gangsters an autonomy society doesn't afford most teens. With plenty of money and no respect for authority, gang members are not limited by responsibilities, as adults with the same autonomy are.

"They used me for my sex again, so I got sexed in by five of their members, during one night, on one bed. I felt, I was excited because I got to be one of them. I really wanted to be one of them and I was willing to do just about anything to be one of them, and then when we got done, I went home and I took at least three showers because I felt so dirty, I just, I didn't like it. Then the next day I forgot about it, because I medicated myself and I was happy because I was one of them now."

—Star, 14-year-old European American, Mankato, Minnesota, Gangster Disciple

Much gang behavior, which mainstream society views as delinquent and criminal, happens in the name of fun. A gangster's idea of fun is different from that of most young people. One "G" described getting shot at as fun, adding, "We got away."

Gang members tell Cavett and Harrington about getting up in the morning, getting dressed, and going to work. They talk about "working as a soldier" and

love. "I have the hardest time with this one," says Harrington. "Imagine these kids meeting on the street greeting each other with, 'I love you.'" Gang love is similar to but seemingly deeper than what college fraternity members call the loyalty of brotherhood.

Sometimes gangs take that loyalty to an extreme by subverting a member's love for his biological family. Some gangs set up home invasions, in which an aspiring gangbanger supplies information about his family, setting them up. The gang then invades the family home to destroy and steal and sometimes rape and murder. The new employee is then deemed worthy of the gang's love, trust, and status.

The need to be powerful in society is seen in people from every walk of life throughout history. Gangsters derive their power through fear and intimidation. Scared or apathetic communities may be complicit in gangs' success. Parents who allow their kids to be

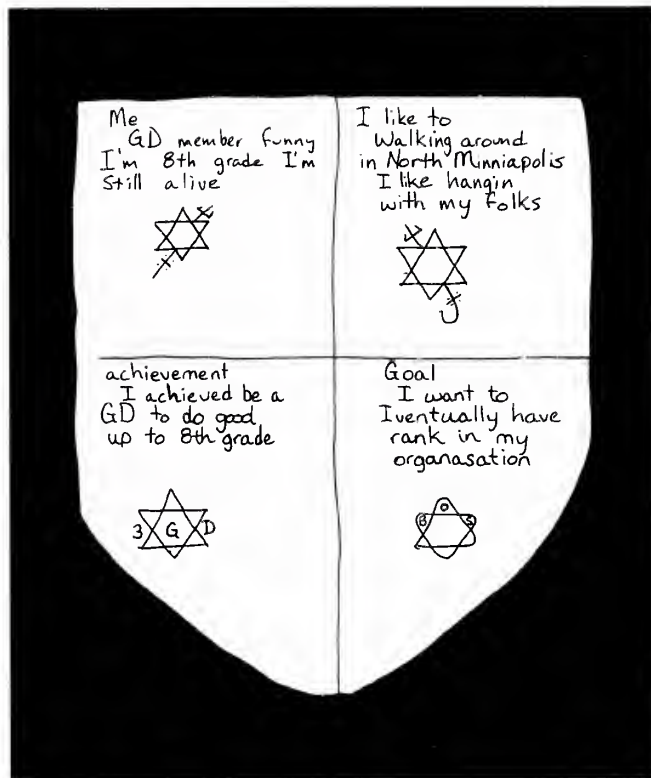
"dressing for battle." Harrington says gangsters channel their warrior spirit as men have done forever.

Gangsters describe an adrenaline rush like that experienced by professional athletes or people who are chemically dependent. Cavett compares the difficulty of leaving gang life to the difficulty of quitting an addiction.

Drug addicts, gambling addicts, sex addicts, workaholics, and gangsters all live for their fix. With an ear tuned to the language of addiction, Cavett tells of teens "throbbing" for the gang life. They shake when they think about it, like a drug addict going through withdrawal. Like an alcoholic who quits drinking only to start again at times of crisis, gangsters often try to quit and are lured back.

Stopping Gangs

Law enforcement fights gangs with three methods: suppression, prevention, and intervention. Arresting



Left: William Glasser's control theory, based on basic emotional needs, serves as a framework for understanding the appeal of gangs. Right: An eighth-grader's school notebook shows his gang affiliation.

and locking up gangsters for criminal acts works, says Harrington. But suppressing gang activity is not enough. Kids in gangs understand the system—they often tell police what they want to hear, clear the system, and return to the streets to bang again.

Harrington explains that he and his colleagues in the police department can only do so much. Too often community members recognize the problem but expect the police to handle it. But police can stop the problem only with effective community support. Affluent communities often deny the existence of the problem—Harrington calls it the “these are our kids, they’re not involved in that” mentality. Police departments may have to wait for a community to face the problem before their work can be effective.

Community Support

By listening to gangsters and better understanding their world, Hand In Hand is part of a growing effort to prevent young kids from turning to gangs in the first

place. The medical community can help with prevention and intervention. Cavett says we all need to take the rose hue out of our glasses and be aware of the problem. “Today we are at the same place we were a few years ago with domestic violence,” she says. “We are starting to understand the problem and are looking for the programs and systems to effectively deal with it.”

Gang members often don’t seek medical treatment when they need it. They tend not to trust doctors—or any authority figures. They expect doctors to call the police, and they don’t need the hassle. But physicians can be alert to signs of gang involvement, such as conspicuous gang clothing or colors (kids may flag their affiliation with bandanas), amateur tattoos, or evidence of gang rape in girls. Girls who are “sexed in” to gangs tend to show the same types of bruises as prostitutes and will claim they are the result of consensual sex. If a patient looks like he or she has taken a gang beating, ask what happened. Ignoring such beatings gives gangs the power to conduct business as usual.

continued

The medical community can also help in nonmedical ways. Many of the kids who try to leave a gang face obstacles. They need help completing their college applications and financial aid requests. Anyone can be a mentor to a kid who's trying to straighten out his or her life. Some of the teens Cavett works with express interest in professional careers. One former gang member said, "I wish I could just follow a doctor around for a day to see what it's like."

The next time you feel like it's not your problem or duty to understand the growing gang epidemic, consider the story of a young man who was doing his best to stay out of trouble. He worked hard in school and avoided the

"... the fact that I could walk around being this big hard-core, hard ass, carry a gun and have all this money, have my friends and the weed, all the drugs. People being scared of me, that's what interested me."

-Little Joker, 15-year-old
Native American,
Latin King,
Hayward, Wisconsin

kids who caused trouble. Every day he walked past a park on his way to school. One corner was Crip territory, another was Latin King territory, and a third was Disciple territory. It was impossible to walk to school without a beating.

He asked his mom, his coach, and his principal what he could do about his walk to school. They were all too busy to help. The young man endured a final beating—a beating in. The next day he walked home as a Latin King. Safely. **MM**

Matt Loskota is a free-lance writer in Minneapolis.

For more information about Hand in Hand, please call Kate Cavett at 612/227-5987.

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ANNOUNCEMENTS

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TASK FORCE FORMING ON ANTIMICROBIAL PRESCRIBING

In response to a resolution passed by the 1997 MMA House of Delegates, the MMA is creating a task force on antimicrobial prescribing practices. David Williams, M.D., an internist specializing in infectious diseases, will chair the task force. Physicians who are interested in participating are encouraged to contact Janet Silversmith, MMA health policy analyst, at 612/378-1875 or 800/DIAL MMA (342-5662).

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STRATHY, MAEDER EARN ACOG LEADERSHIP POSTS

Janette Strathy, M.D., an ob/gyn at Park Nicollet Medical Center, has been elected to a three-year term as vice chair of District 6 of the American College of Obstetrics & Gynecology.

Edward Maeder Jr., M.D., also an ob/gyn at Park Nicollet, has been elected assistant secretary of the executive board of ACOG, a national position with a one-year term. Maeder previously served as chair of District 6.

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DNR FORM AVAILABLE

The MMA reminds members about the availability of its Emergency Care Guidelines for Resuscitation document, adopted in 1993 for all nonhospital settings and reaffirmed in a resolution to the 1997 MMA House of Delegates. The document allows an individual the option of limiting emergency care when appropriate; it can be used in any setting where emergency care is needed. To obtain a copy, call 612/378-1875 or 800/DIAL MMA.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

Bill to End Provider Tax Fails—This Year

Despite valiant efforts by MMA members, staff, and many other health and tobacco-control advocates, an amendment to the House Tax Bill to raise the tobacco tax 40 cents per pack and eliminate the provider tax failed 88-43 on the House floor March 11.

But discussions of the proposal showed an increasing awareness among lawmakers of the need to find more suitable ways to fund the MinnesotaCare program, said David Renner, MMA director of state and federal legislation.

Eliminate Provider Tax in '98

"There is a growing realization that the provider tax does not work and needs to be replaced," Renner said. "With a new governor next year we will be pursuing replacing the provider tax entirely."

The amendment was offered by Rep. Tom Huntley, DFL-Duluth. It was debated for over an hour, with several legislators—Rep. Lee Greenfield, DFL-Minneapolis; Rep. Matt Entenza, DFL-St. Paul; and Rep. Phyllis Kahn, DFL-Minneapolis—speaking passionately in support of it, Renner said.

Kahn had earlier offered a similar proposal in the House Tax Committee, which was tabled before legislators could vote on it.

Gov. Arne Carlson had indicated he would support the plan to impose the cigarette tax hike along with a provider tax cut, as long as it resulted in "no new net taxes."

Legislators who spoke against the proposed amendment included

See pages 36-38 for more coverage of state legislation.

Rep. Mike Osskopp, R-Lake City; Rep. Steve Dehler, R-St. Joseph; Rep. Irv Anderson, DFL-International Falls; Rep. Ron Erhardt, R-Edina; Rep. Tom Rukavina, DFL-Virginia; Rep. Steve Sviggum, R-Kenyon; and Rep. Kevin Goodno, R-Moorhead. Renner noted that all of these legislators declared their opposition to raising the tobacco tax—not necessarily to reducing the provider tax.

Renner expressed disappointment that many members of the House who initially indicated support for the amendment ultimately voted against it.

Tobacco Lobby Fought Proposal

"It's clear that the tobacco lobby continues to exert a great deal of influence in Minnesota," Renner said. "This was a chance to do the one thing that has been shown to reduce teen smoking—raise the price—and a majority of legislators were unwilling to do it."

The MMA sent alerts to all Minnesota physicians urging them to voice support for the proposal. Raising taxes on cigarettes has proven to be an effective tool for reducing smoking among young people, which in turn reduces health care costs. Eliminating the provider tax would also lead to lower overall health care costs by eliminating the costs of administering, collecting, and paying the tax.

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Viewpoint

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Kent S. Wilson, M.D.
President, Minnesota Medical Association

Help MMA Develop State's Response to E&M Guidelines

Gerald Onstad, M.D., former head of the GI Medicine Section at Hennepin County Medical Center, retired on February 28 at the relatively young age of 61. A significant reason for his premature retirement was that Medicare Evaluation & Management (E&M) Documentation Guidelines were due to be implemented on his service March 1. Dr. Onstad had no desire to deal with this bureaucratic hassle. Of course, this was not his only reason. No single factor causes a physician to retire. But it is disturbing that the E&M guidelines would be a major factor in his decision.

I asked Dr. Onstad why he was so vehemently opposed to the guidelines. He said they require physicians to record volumes of irrelevant or inconsequential data, take a great deal of time away from teaching medical students and residents, and undercut the teaching program's system of having staff and residents share responsibility for patient care. The guidelines interfere with the physician/patient relationship by requiring doctors to spend more time on record keeping and less on patient care. He added that the coding guidelines seem designed to allow people with limited skills to audit medical records for fraud and abuse.

Dr. Onstad's observations mirror comments that many other physicians have shared with me regard-

ing the excessively complex and burdensome E&M coding guidelines. It is a widely held view that the guidelines depart from the lean and elegant practice of medicine, which emphasizes clear documentation of the pertinent historical and physical findings, both positive and negative, that support diagnostic conclusions and treatment recommendations.

The proposed E&M guidelines dramatically increase the need to record information that may not be relevant to the problem at hand, resulting in a tremendous increase in administrative time and expense. Useful information may be buried in a mountain of irrelevant data. There's more work; less substance.

The E&M guidelines evolved over several years following Medicare's implementation of the Resource-Based Relative Value Scale in 1992. The Health Care Financing Administration, acting without input from organized medicine, developed a set of documentation guidelines in 1993. When physicians strongly objected, HCFA withdrew them. The AMA, national specialty organizations, and HCFA developed new guidelines in 1994 and updated them in 1997. Once again the response was negative. Physician complaints about the content and limited time allowed for education led the AMA to request a delay. HCFA extended the implementation date to July 1998, which now looms before us.

Although use of the guidelines is voluntary, many physicians fear that not following them could lead to sanctions. We feel caught in a vice the jaws of which are onerous guidelines and fraud and abuse sanctions.

Responding to physician frustration, the MMA is investigating ways to make the guidelines less cumbersome and to make sure that physicians will not be prosecuted unfairly for inadvertent coding or documentation errors.

Last month, I was part of an MMA delegation that traveled to Washington, D.C., to alert our Minnesota legislators to the controversy surrounding the guidelines. As a result of this visit, Rep. Gil Gutknecht called for a hearing on E&M guidelines by a subcommittee of the House Government Reform and Oversight Committee. We believe our Minnesota delegation should be kept informed on this important issue.

To make sure that Minnesota physicians play a key role in the national debate, the MMA has scheduled a Minnesota Summit on E&M Documentation Guidelines for April 14 in Minneapolis. Although many of us would like to see the E&M guidelines simply disappear, we realize that eliminating them is not an option. Our goal is to develop specific recommendations for correcting the guidelines and bring these ideas to an AMA "fly-in" to Chicago on April 27. This meeting will include representatives of state and specialty associations, HCFA, and the AMA. The MMA plans to propose specific recommendations for revisions, based on the suggestions of MMA members.

Participating in the summit is an excellent way to make sure your concerns are reflected in the MMA message. If you are unable to attend, please share your ideas with us by calling Janet Silversmith at 612/378-1875 or 800/DIAL MMA (342-5662), or e-mailing her at jsilversmith@mnmed.org

This is an opportunity for us to work together to reduce our administrative burden. We hope to shift the balance from paper care to patient care.

.....

AMA's O'Brien, Mahood Discuss Model Managed Care Contract



Attorney Carol O'Brien, director of the AMA's new Division of Representation, and AMA Trustee William H. Mahood, M.D., discuss the Model Managed Care Medical Services Agreement at the MMA-sponsored contracting seminar February 24.

MMA Plans Summit on E&M Documentation Guidelines

The MMA has scheduled a summit to gather recommendations from Minnesota physicians for improving Medicare's documentation guidelines for evaluation and management (E&M) services.

The MMA is working vigorously—and quickly—with the American Medical Association to correct the revised guidelines during the six-month implementation delay, effective until July.

The summit is slated for Tuesday, April 14, from 5:15 to 9:15 p.m. at the Sheraton Minneapolis Metro-

dome. MMA health policy analyst Janet Silversmith will attend the summit, and will bring recommendations formulated there to an AMA work session in Chicago on April 27.

"The MMA has heard a significant number of negative comments about the guidelines," Silversmith said. "We believe that holding a statewide summit to review them will offer a critical opportunity for physicians to voice their concerns and suggest changes." Silversmith said a representative of the AMA will also attend the MMA gathering.

Three Quarters of Membership Renewed by April

♦♦♦♦♦THANK YOU TO EVERY ONE of the 78 percent of MMA members who has renewed his or her MMA membership for 1998.

Reminder notices have been sent to members who have not yet renewed their memberships, or who elected to renew on the installment plan. Members are encouraged to remit the balance of their membership dues for this year as soon as possible to ensure continuity of benefits and services.

The involvement of physicians from all specialties and from throughout the state ensures effective representation at the Capitol and in the regulatory arena. Your continued involvement is important. If you recently received a reminder notice, please renew your membership immediately. If you have questions about your current membership status, please contact the membership and dues processing staff at 800/DIAL MMA (342-5662).

A review of general multisystem exam guidelines will be done in a large group setting, then single system exam guidelines will be reviewed in two concurrent sessions, Silversmith said.

Boxed dinners will be provided for participants. A nominal fee may be charged. For registration information, contact Vicki Westling at the MMA at 612/378-1875 or 800/DIAL MMA (342-5662).

If you have any questions about the guidelines, or if you have specific comments or examples of problems and are unable to attend the summit, contact Janet Silversmith at the same number.

♦♦♦♦♦

MMA Participates in ECFE Rally at State Capitol

The Minnesota Medical Association displayed Prescription for a Healthy Baby information at the Capitol on March 10 as part of Early Childhood Education Parent Rally Day. Parents and children came to the Capitol to thank their legislators for supporting ECFE and Learning Readiness programs.

MMA member Rep. Richard Mulder, M.D., R-Ivanhoe, spoke at the rally, stressing the importance of experiences in the first three years of life in determining whether children reach their full potential.

In December, the MMA sent clinics bright yellow prescription pads with the heading "Prescription for a Healthy Baby." Patients may tear off prescriptions that list phone numbers for two major statewide parent education providers, Early Childhood Family Education (ECFE) and MELD, formerly Minnesota Early Learning Design. Also included in the mailing was the "Physician Resource Guide for Parents of Babies and Toddlers," which includes brief talking points about the importance of the first three years of life in child development and lists resources such as Family Nutrition Programs, the Greater Minneapolis Day Care Association, and Urban Ventures



Rep. Richard Mulder, M.D., R-Ivanhoe, speaks at Early Childhood Education Parent Rally Day at the State Capitol March 10. Mulder is a family physician and MMA member.

Center for Fathering, as well as helpful Web sites.

For more information, call Lorrie Holmgren at 612/378-1875 or 800/DIAL MMA (342-5662). •••••

MMA Opposes Minor Consent Amendment

•••••THE MMA OPPOSES AN amendment, offered by Rep. Tim Pawlenty, R-Eagan, to the Health and Human Services Omnibus Bill, S.F. 3346, that would allow parents access to the medical records of their unemancipated minor children. The amendment would have the potential to cause youths to defer or avoid needed health services, since it would eliminate any guarantee of confidentiality. "Parents should be involved in their children's health care decisions," said David Renner, MMA director of legislation and public policy. "However, there are cases, such as those involving an abusive parent, where the child's confidentiality rights outweigh the parents' need to know." The bill was in a conference committee at press time.

Children's Endowment Fund Proposal Advances

An MMA-endorsed proposal to create a permanent endowment for Minnesota's children easily passed the Senate March 18 on a 62-4 vote. The passage of S.F. 2775-Hottinger is the first step in developing the endowment; it authorizes placing a constitutional amendment on the ballot this fall.

The bill's author, Sen. John Hottinger, DFL-Mankato, cited findings highlighted in the MMA's "Prescription for a Healthy Baby" campaign in pushing for the legislation.

If approved by voters, the endowment fund would make available approximately \$20 million annually for research and activities to enhance brain development of children (from birth to age 6 in the Senate version, and for kids up to age 4 in the House version). Constitutional protection would prevent money from the endowment from

being diverted to other uses.

The bill was in the House Rules Committee as *The Monitor* went to press.

In the Senate version, money for the trust fund would come from the existing School Trust Fund, comprised of money from timber sales, leases, and other uses of land held in trust and managed by the Department of Natural Resources. Ostensibly, the endowment fund would also receive private contributions. The House bill does not indicate a funding source at this time.

MMA President Kent Wilson, M.D., said in a letter to Sen. Hottinger that the endowment fund would help "enhance young children's physical, emotional, and intellectual development," and called it "an investment in Minnesota's future."

•••••

House/Senate Split on Abortion May Doom HHS Bill

Controversy over abortion provisions could block final passage of the omnibus health and human services bill. An amendment to the House bill bans partial-birth abortions, and requires physicians to submit annual reports on any abortions they performed in the previous year to the commissioner of health; the Senate bill does not contain such a provision.

The American Medical Association supports banning intact dilation and extraction, but the MMA has no position on the issue. The provision to require detailed reporting on all abortions, however, raises strong concerns as a potential threat to the physician-patient relationship.

The House bill requires physicians to report any abortions performed, the method used, the gesta-

tional age of the fetus, the age of the mother, the reason for the abortion, the type of anesthetic, the disposal method, the payment method, any complications, and fees collected. The commissioner of health would be required to issue an annual report summarizing this information. Although the report would not name individuals, it is not clear whether the information on physicians would be public and thus accessible to anyone.

As *The Monitor* goes to press, the two versions of the bill are in a conference committee in which 10 members of the House and Senate are trying to work out the differences between the versions. A majority of the House—75 of 134 members—has pledged not to vote for final passage of the conference bill unless

it includes the dilation and extraction ban and the abortion reporting requirements.

Since Senate conferees are unlikely to accept the abortion provisions, the stage was set for a showdown in the Legislature, according to David Renner, MMA director of state and federal legislation. Hardball politics could prevent passage of a bill that includes funding for a fetal alcohol syndrome prevention and intervention program, medical education and research, access to KidCare, and nursing homes.

The MMA sent a letter to the conferees outlining its support for key funding provisions in the omnibus bill, as well as its opposition to provisions such as the abortion reporting amendment.

Gov. Arne Carlson indicated he may not sign the omnibus health and human services bill if it contains both abortion provisions, Renner said.

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LEGISLATIVE NEWS

FAS LEGISLATION PASSED IN HOUSE, STALLED IN SENATE

Legislation that would allow—but not require—physicians to report pregnant women who are abusing alcohol was passed by the House March 10. The bill is on the Senate floor awaiting final action as *The Monitor* goes to press; when taken up earlier, an attempt to add a partial birth abortion amendment caused the bill to be laid over.

The MMA worked with First Lady Susan Carlson, who led the Governor's Task Force on Fetal Alcohol Syndrome, and the bill's authors to remove mandatory reporting and civil commitment provisions from the legislation. The amended version of H.F. 3184-Skoglund gives physicians immunity both for good faith reporting and for failure to report a pregnant woman who is abusing alcohol.

Two other legislative proposals—one from each chamber—in the health

and human services omnibus bill would appropriate money for a FAS research, prevention, and intervention initiative. The House version allocates \$3.5 million for the program, while the Senate version allocates \$3 million. A conference committee was expected to begin reconciling the proposals, but the fate of the entire omnibus bill was in question due to controversy over two abortion provisions (see article above).

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SENATE OKs PROVISIONAL DRIVER'S LICENSES FOR KIDS

The Senate overwhelmingly (43-19) approved legislation to enact provisional driver's licenses for kids 16 and 17 years of age. The legislation, S.F. 2407-Junge, would require drivers under age 18 to have a provisional license for at least 12 months. During the provisional period, the driver would be allowed no more than one ticket and zero

motor vehicle accidents. The driver also would be required to complete 10 hours of supervised driving with an adult older than age 21 in the vehicle, and would be required to have a driver's permit for at least six months prior to that period (or three months prior to that period if he or she completed an accredited, behind-the-wheel instruction class). During the period in which the driver has a permit, he or she must maintain a clean driving record and have no DWI convictions. A provision prohibiting 16- and 17-year-old drivers from driving between midnight and 5 a.m. was removed from the Senate version.

The companion bill in the House, H.F. 2532-Chaudhary, passed the House Transportation Committee and the House Ways & Means Committee. That version includes the curfew provision. The MMA supports this legislation as consistent with efforts to reduce teenage driving accidents.

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LEGISLATIVE NEWS

MMA's DEA LEGISLATION AWAITS GOVERNOR'S SIGNATURE

The MMA's DEA bill was awaiting Gov. Arne Carlson's signature as *The Monitor* went to press. The legislation to prohibit use of physicians' DEA (Drug Enforcement Agency) numbers for profiling and general tracking was sponsored by Sen. John Hottinger, DFL-Mankato, in the Senate and by Rep. Thomas Huntley, DFL-Duluth, in the House. Controversy surrounding the proposal subsided when an amendment delaying the effective date was added. The legislation now provides that 24 months after the federal government develops a new national provider identification number, health plans, pharmacies, and drug manufacturers will not be allowed to use the DEA number for purposes other than enforcing controlled substance laws.

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DWI BILL STILL ALIVE, WEAKENED IN SENATE

A severely weakened version of the MMA-endorsed proposal to lower the legal blood alcohol content for drivers from .10 percent to .08 percent passed the Senate floor March 12. An amendment to S.F. 2099-Foley applies the .08 percent standard only to individuals who have had more one or more DWI arrests in the past. The bill's Senate author, Sen. Leo Foley, DFL-Anoka, said he believed the amendment was an attempt to kill the bill, since having two different standards would substantially increase the cost of policing drunk driving.

The bill's companion, H.F. 2389-Entenza, had moved to the floor but had not yet come up for a vote by the time *The Monitor* went to press. The House version, authored by Rep. Matt Entenza, DFL-St. Paul, did not contain the second-offense amendment. MMA political analysts

predicted that the two bills would end up in a conference committee, where they hoped the stronger version would prevail.

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PROPOSAL WOULD RESCUE CANCER SCREENING PROGRAM

An amendment offered by Rep. Gail Skare, DFL-Bemidji, to the Health and Human Services omnibus bill would fully offset federal funding cuts to a statewide breast and cervical cancer screening program for low-income women. The Minnesota Breast and Cervical Cancer Control Program (MBCCCP), funded by the federal Center for Disease Control and Prevention, provides cancer screening for women who are uninsured or underinsured. The CDC reduced funding for MBCCCP by 25 percent (\$1.3 million) in 1997; an earlier proposal in the House sought to allocate \$989,000 to the program. Skare's proposal would allow the Minnesota Department of Health to make up the full \$1.3 million. The Senate version proposes allocating \$910,000 to the screening effort. The MMA is one of many health care organizations, including the Minnesota division of the American Cancer Society, that support offsetting the federal cuts with state funding for MBCCCP.

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PRESIDENT CLINTON PROPOSES MEDICARE USER FEES

President Clinton's proposed budget includes some proposals to impose Medicare "user fees" on physicians, said Janet Silversmith, MMA health policy analyst, "as an alternative method of financing." Proposals include charging physicians an enrollment registration fee of \$100 initially and \$25 for renewals, and imposing a \$1 per claim fee for paper claims—which presumably

would also serve as an incentive to submit claims electronically, Silversmith said.

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MMA MEMBERS TAKE PART IN AMA LEADERSHIP CONFERENCE

A delegation of Minnesota physicians traveled to Washington, D.C., to participate in the AMA National Leadership Conference March 8-11. Delegates participated in a variety of programs on subjects ranging from negotiations and contract resolution to education about the AMA's end-of-life care project. Breakout sessions were offered in subjects such as speechwriting, innovations to improve practice performance, and the "corporatization" of health care.

The conference opened with a presentation on managing crisis and change by retired U.S. Army General Colin Powell, who served as Chairman of the Joint Chiefs of Staff in the Bush Administration. Federal health care legislation was discussed by President Clinton; Speaker of the House Newt Gingrich, R-Ga.; Sen. Phil Gramm, R-Texas; and Sen. Edward Kennedy, D-Mass. Rep. Bill Thomas, R-Calif., of the House Subcommittee on Ways and Means also spoke. Nancy-Ann Min DeParle, administrator of the Health Care Financing Administration, discussed recent HCFA rulings affecting physicians.

After the meeting, Minnesota delegates shared the MMA's viewpoint on a number of issues with members of the state's congressional delegation. Minnesota physicians attending the conference included MMA President Kent Wilson, M.D.; Board Chair Paul Matson, M.D.; President-elect Judith Shank, M.D.; MMA Vice-President Anthony Jaspers, M.D.; trustee Benjamin Whitten, M.D.; MMA CEO Paul Sanders, M.D.; William Schoenwetter, M.D.; and Edward Spenny, M.D.

MMA Joins Medicines Work Coalition

.....THE MMA HAS JOINED A coalition of health care groups aiming to educate the public about the importance of prescription drug compliance and the value of appropriate medicines.

The Medicines Work Coalition and its public awareness campaign are sponsored by the Pharmaceutical Researchers and Manufacturers of America (PhRMA). The first of several advertisements in the campaign, a print message about a child who helps reduce health care costs in Minnesota simply by taking his asthma medicine, ran in the *Star Tribune* March 19.

"Johnny Smith has asthma," the ad reads. "For too long, he suffered severe attacks that often resulted in a trip to the hospital emergency room. But thanks to a new prescription medicine, not only are his attacks less frequent and less severe, Johnny's also helping to control health care costs in Minnesota. That's because his new prescription medication costs only a fraction of a single trip to the emergency room."

MMA Member Joins Antiviolence Coalition Board of Directors

David McCollum, M.D., will represent the Minnesota Medical Association on the board of directors of the Health Care Coalition on Violence.

McCollum, an MMA member, is an emergency physician with Emergency Physicians and Consultants, P.A., of Waconia, Minnesota. He has co-chaired the coalition's Practice Guidelines, Education and Training Committee since 1996.

McCollum said he hoped his role on the board might help give the MMA—which has worked extensively on violence as a health issue, most notably in its nationally renowned Stop the Violence campaign—"more of an interface" with medical schools. "I'd like to help the MMA have more of an impact on the training of physicians," McCollum said.

He also is a board member of the organization Physicians for a Violence-Free Society, and serves on a working group of the Minnesota Center Against Violence and Abuse, which is developing a plan to educate health care providers about violence.

McCollum also serves as a city health officer for Chanhassen, Minnesota, and is a clinical associate professor in the University of Minnesota's Department of Family Practice.

He wrote an article for the October issue of *Minnesota Medicine* entitled "When Symptoms Defy Diagnosis," which maintains that patterns of illness or disease that are difficult to diagnose or treat may be the results of personal violence.

One task of the coalition is to envision the ideal health care environment for effective intervention in family violence situations, then to filter that into practical goals and policies, McCollum said.

"We're trying to define what a best-case scenario in a health care setting is," he said. "If we were going to do everything right, what would that look like? Then [we'll] pilot that to see what's realistic, what's reasonable to ask for."

The MMA is a member of the Health Care Coalition on Violence, formed in 1996 by the Governor's Task Force on Violence as a Public Health Problem.

MMA to Cosponsor National Patient Safety Foundation Regional Meeting

The Minnesota Medical Association, along with 3M and Schering-Plough, is cosponsoring a June 1 regional meeting of the National Patient Safety Foundation in St. Paul. The meeting will be held at 3M's corporate headquarters.

The nonprofit National Patient Safety Foundation was created by the American Medical Association to "improve health care safety by

studying why errors in the health care system occur and implementing safeguards to prevent such failures from injuring patients."

Abstracts on Enhancing Patient Safety Sought

Individuals are invited to submit abstracts if they are interested in presenting at the conference on Enhancing Patient Safety and Reducing

Errors in Health Care, slated for November 8-10 at the Annenberg Center for Health Sciences in Rancho Mirage, California. In addition to the Annenberg Center, sponsors include the National Patient Safety Foundation, the American Association for the Advancement of Science, the Joint Commission on Accreditation of Healthcare Organizations, and the U.S. Department of Veterans Affairs. To obtain a copy of the Call for Abstracts, contact NPSF at 312/464-4848. The deadline for the receipt of abstracts is July 1.

Latex Allergy Conference Is May 5

•••••A TWIN CITIES AUDITORIUM will serve as a "downlink site" for a live satellite video conference on natural rubber/latex allergy. "Natural Rubber/Latex Allergy: Recognition, Treatment and Prevention" will feature interactive presentations, broadcast by satellite, from renowned authorities throughout the United States and Canada. Experts will offer up-to-the-minute information on identifying and managing natural rubber/latex allergy, and will discuss prevention and accommodation strategies for health care and occupational settings.

The conference will be broadcast May 5 from noon to 3:15 p.m. at the Vance De Mong Auditorium, North Memorial Health Care, Robbinsdale, with registration starting at 11:30. To obtain a registration form, call Lisa Miller of Medical Alley at 612/542-3077.

Dr. Holtan Featured in AMNews Story on Survivors of Torture

MMA member Neal R. Holtan, M.D., a staff physician at the Center for Victims of Torture in Minneapolis, was featured in a March 16 *American Medical News* article about survivors of torture. Holtan, who helped establish the center, is an internist specializing in general preventive medicine. He is a member and past chair of the MMA Committee on Public Health and Preventive Medicine.

Holtan spoke about the way physicians at the center work to help survivors from cultures around the world begin to feel safe and connected. "The physicians here first establish a relationship with the people. 'The doctor' is pretty much a common cultural concept the world over," he said. "It's an anchor for trust and building trust."

He also discussed why it's important for a physician with patients who are immigrants to ask what country they came from and why they left, and record the answers in the medi-

cal history. As Chicago internist Irene Martinez, M.D.—a torture survivor from Argentina—said, "Moving from one country to another is a big effort; it's common sense to ask why."

Simple, direct questions are best, Holtan said: "Were you imprisoned? Were you tortured? Were you sexually abused? Were you a political prisoner?" It's almost [as if doctors] are afraid to ask those questions. But they needn't be, because if the person was [tortured], they would be grateful someone asked. And if they weren't, they don't care."

He added that sometimes, a physician treating a survivor of torture can help the patient a great deal simply by treating—or ruling out—diseases or injuries. "You can do that reassurance: 'No, they didn't damage your heart; your lungs sound normal."

"It's a challenge to win trust," Holtan said. "I just take it minute-by-minute and day-by-day, and take what I can get. Any amount of trust is a step forward." •••••

MMA Participates in Peer Review Data Confidentiality Talks

Legal staff from the MMA, the Minnesota Hospital and Health-care Partnership, and several other interested parties have been meeting with Rep. Lee Greenfield, DFL-Minneapolis, about an ongoing dispute over the confidentiality of peer review data.

For several years the state Board of Medical Practice and staff from the attorney general's office have been trying to gain access to peer review data maintained by hospitals in Minnesota, said Patricia Franklin, MMA legal director. The MMA, MHHP, and other provider organizations have continued to assert the "sanctity of peer review materials," Franklin said. "Our concern all along has been that opening this data to regulatory agen-

cies will harm the peer review process. Peer review is intended to be a quality improvement tool."

Participants in the March 19 meeting, which also included a representative of HealthSystem Minnesota, discussed "what kind of materials the board currently has access to, according to the law, to do its regulatory work," Franklin said.

Rep. Greenfield has indicated a willingness to seek a legislative solution if the two sides involved fail to reach an agreement, she said.

"It was a good discussion, (although) no hard and fast solutions were reached," Franklin said. Another meeting of the same parties, minus Rep. Greenfield, was scheduled as *The Monitor* went to press.

The Monitor

APRIL 1998

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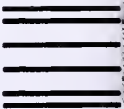
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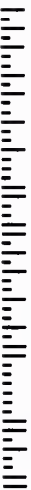
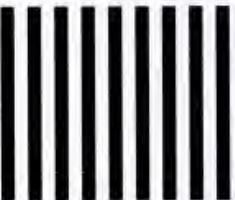
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* New England Journal of Medicine, February 1991

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Somali Refugee Health Screening in Hennepin County

Mary Jo Fritz, M.S., R.N., and Linda L. Hedemark, M.D., F.A.C.C.P.

ABSTRACT

Somalis are one of the newest refugee groups to settle in Minnesota, first arriving in 1993. The largest number of Somali refugees in Minnesota live in Hennepin County, which received 85% of the state's Somali refugees in 1996. In this population, tuberculosis, parasitic diseases, and malaria are of particular concern. In 1996 Somalis accounted for 27% of the foreign-born cases of tuberculosis in Minnesota. Before entering the United States, all refugees are given an overseas health assessment, which focuses on identifying conditions that might be contagious. The examination is limited and is valid for one year. Domestic refugee health assessment is very important, since it provides a comprehensive medical evaluation and treatment plan for health conditions that may interfere with successful resettlement.

Refugees and immigrants from Somalia are a rapidly growing population in Minnesota, particularly in Hennepin County. The first 66 Somali refugees arrived in Hennepin County in 1993.¹ From 1993 to 1996, 825 Somali refugees settled in Hennepin County,¹ not including those who arrived as secondary migrants or immigrants. Refugees who enter the country in another state and relocate to Minnesota are considered secondary migrants. The exact number of secondary migrants and immigrants is significant but unknown. This article describes Somali refugees, refugee health screening, and some of the unique needs of this population.

The United States is home to immigrants from many countries throughout the world. These new arrivals bring with them their cultures and traditions and establish themselves in the American economy and society. Immigrants who enter the United States in restricted numbers are refugees or family members of refugees or immigrants who are not U.S. citizens. Immigrants who enter in unrestricted numbers are immediate relatives of a U.S. citizen. While immigrants come to this country voluntarily, refugees come be-

cause they have been displaced from their own country, which happens for many reasons, including war, oppression, and persecution.

The United States takes in about 1% of the world's refugees. In the 1996 fiscal year, 73,500 refugees were admitted. They came from Africa, Eastern Europe and the former Soviet Union, and from parts of Asia, Latin America, and the Caribbean. From 1979 to 1994, refugees and immigrants to the United States came primarily from Southeast Asia; arrivals from all other countries, including Somalia, accounted for only about 6% of the total number of refugees.²

In 1996 the majority of refugees who settled in Minnesota were from the former Soviet Union (29%), Somalia (25%), and Laos (20%) (See Figure 1). Overall, Hennepin County received 60% of the refugees, including 85% (458/538) of the state's Somali refugees and 68% (428/631) of the state's refugees from the former Soviet Union.¹

SOMALI REFUGEES: BACKGROUND

Somalia is an African country bordered by Kenya, Ethiopia, Djibouti, and the Indian Ocean (Figure 2). The

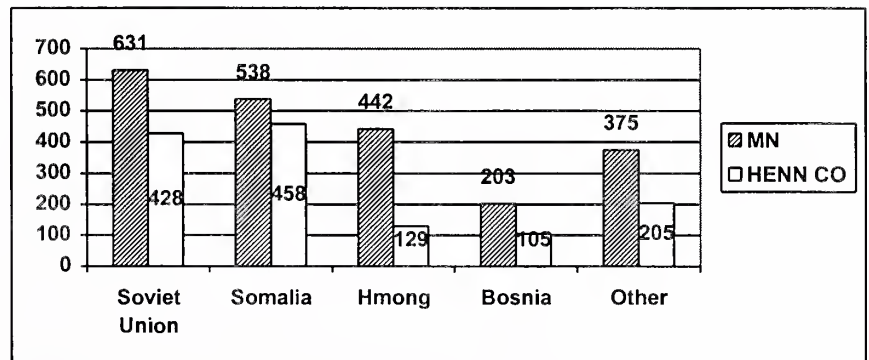


FIGURE 1—1996 refugee arrivals to Minnesota and Hennepin County

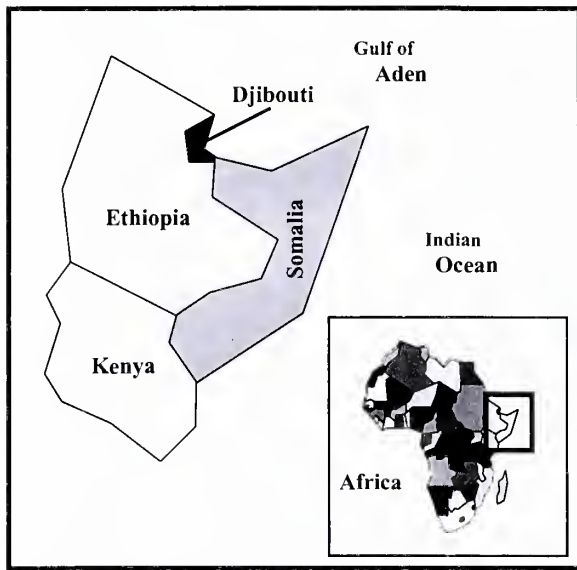


FIGURE 2—Somalia

country, about the size of Texas, is mostly flat, hot, and dry. The language is Somali. Middle-aged and educated Somalis may speak English, but most young people do not understand or speak English. Somalis do not have surnames, as in Western culture. They use three names: a given name, the father's given name, and the grandfather's name. Many names are similar since Somalis have one pool for all three names. Islam is the primary religion, and Somalis who practice their faith do not drink alcoholic beverages and do not eat pork. Their diet is generally low in calories and high in protein.²

Before the civil war in Somalia, which began in the late 1970s, many of the Somali people were farmers, shepherds, or herders. About 20% of the estimated 7.7 million people lived in the cities and worked in mills or operated import/export shops. As early as 1920, Somali immigrants began coming to the United States. Most worked as sailors, some in the steel mills; many became naturalized citizens. In the 1960s many Somali students came to the United States to study, then returned to their homeland. When the civil war intensified in the late 1980s, nearly half of all Somalis were forced from their homes, and by 1992 starvation threatened about one-fourth of the population. Some Somalis escaped to refugee camps in the bordering countries of Kenya and Ethiopia.²

Somali refugees began to arrive in the United States in the mid-1990s, and some started resettling in Minnesota in 1993. Somalis came directly to Minnesota from refugee camps in Kenya and Ethiopia (primary migrants) or from other states (secondary migrants). Only primary refugee arrivals are reported to the Minnesota Department of Health; there is no mechanism to keep track of secondary migration in the United States.¹

OVERSEAS MEDICAL EXAMINATION

Before Somali refugees resettle in the United States, they receive a medical examination to screen for conditions that would prohibit them from entering this country. A panel of physicians appointed by the U.S. Embassy or Consulate conducts the exams. Federal agencies oversee the examination process for all immigrants and refugees. Conditions that would prevent entry into the United States include "communicable diseases of public health significance; current or past physical or mental disorders that are or have been associated with harmful behavior; drug abuse or addiction."³ The exam is intended to identify conditions that might be harmful to the general U.S. population—it is not a comprehensive health exam and not intended to identify all health conditions. The findings from the exam are valid for one year, and most refugees travel within that year.³

The exam includes a tuberculosis (TB) screening; an HIV antibody test with pre- and post-test counseling; a blood test for syphilis for any refugee age 15 and older; and physical exams for other sexually transmitted diseases (STDs) and for leprosy. If infectious TB, syphilis, other STDs, or leprosy are found, treatment is started; depending on the disease, resettlement may be delayed until the person is no longer infec-

tious. In addition, the physicians ask the refugee about other physical or mental disorders. These conditions may be overlooked if documentation is not available or not presented to the reviewing physicians.³

TUBERCULOSIS SCREENING: OVERSEAS EXAM

All refugees age 15 and older must have a chest x-ray to determine the presence of active TB. The overseas TB screening can determine the presence of clinically active disease only—it does not screen for TB infection. No Mantoux skin tests are done.

If the chest x-ray reveals an abnormality consistent with TB, the refugee is given a designation of Class A or Class B, based on the screening results. This classification is recorded on the person's medical report form (Table 1). Persons with Class A medical conditions must be evaluated within seven days of arrival to the United States. Those with Class B medical conditions need to be assessed within 30 days of arrival.³

DOMESTIC HEALTH ASSESSMENT

While the overseas exam for refugees focuses on identifying conditions that may exclude them from entry into the United States, the domestic health assessment is designed to "eliminate health related barriers to successful resettlement while protecting the health of the U.S. population," according to the Refugee Health Coordinator Network, a national ad hoc group representing state and local refugee health program coordinators.³

When a Somali refugee relocates to Minnesota, the U.S. Public Health Service Quarantine Station at the point of entry notifies the Minnesota Department of Health (MDH) that the refugee will be arriving, and MDH notifies the local (county) health department. The local health department contacts the refugee and explains what the state health assessment is, its purpose, and its value, and strongly urges the refugee to be screened. The health department either provides the screening or helps the refugee to obtain the screening through his or her physician. Many refugees already have Medical Assis-

tance or other insurance.⁴

Not all states implement all portions of the domestic health assessment, which is important to note when refugees move from state to state. In addition, medical records may not follow the refugees when they move within the United States. If health information is not available, a baseline health assessment should be done. Providing the refugee with a card that identifies what parts of the health assessment were completed helps to avoid duplication of screening efforts when refugees move.

RECOMMENDATIONS FOR THE DOMESTIC HEALTH ASSESSMENT

Even though health assessment programs vary from state to state, most include an evaluation as outlined in Table 2 (page 46). MDH also recommends tests to screen for sexually transmitted diseases, including syphilis if the refugee is symptomatic or comes from an endemic area, such as Sudan. In addition, appropriate tests for malaria should be done if the refugee is symptomatic.⁴ In the Somali population, TB, parasitic diseases, and malaria are of particular concern.

After a health assessment is completed, the Minnesota Refugee Health Assessment Form is completed and returned to the Refugee Health Unit at MDH. These reports assist with evaluating the objectives of the refugee health program and provide data to better understand the health needs of refugees entering the state.⁴

DOMESTIC HEALTH ASSESSMENT: MALARIA AND PARASITIC DISEASE

The malaria risk in Somalia is primarily in the southern regions of the country. Some Barawan Somali refugees come to Minnesota from encampments near Mombasa, Kenya. Malaria prevalence in the general population of this region of coastal Kenya is reportedly as high as 30%. *Plasmodium falciparum* is the most common type of malaria in the area. A recent survey of Barawan Somali refugees found that 7% were positive for malaria.⁵

There are no data available about the prevalence of malaria among Somali refugees in Minnesota. While exact numbers are not known, sever-

Table 1

A and B classification for tuberculosis screening¹

Test Results	Classification
Abnormal chest x-ray or series of chest x-rays suggestive of current pulmonary TB AND One or more positive sputum smear examinations for acid-fast bacilli	Class A - Tuberculosis, infectious
Abnormal chest x-ray or series of chest x-rays suggestive of active TB AND History of one or more sputum smears positive for acid-fast bacilli AND Currently on recommended treatment AND Sputum smears negative for acid-fast bacilli	Class A - Tuberculosis, infectious, on treatment
Abnormal chest x-ray or series of chest x-rays suggestive of active TB AND Sputum smears negative for acid-fast bacilli	Class B1 - Tuberculosis, clinically active, not infectious
X-ray or other evidence of extrapulmonary tuberculosis, clinically active	Class B1 - Extrapulmonary tuberculosis, clinically active, not infectious
Abnormal chest x-ray or series of chest x-rays suggestive of TB, not clinically active AND Sputum smears negative for acid-fast bacilli	Class B2* - Tuberculosis, not clinically active, not infectious

¹ Centers for Disease Control and Prevention. Technical instructions for medical examination of aliens in the United States. Atlanta, Georgia: Centers for Disease Control and Prevention, June 1991.

*Persons who have completed a recommended course of antituberculous therapy and whose chest x-rays are stable should be reported as Class B2—tuberculosis, treatment completed.

al cases were diagnosed in Somali refugees screened at the Health Assessment and Promotion unit at the Hennepin County Community Health Department. The domestic health assessment should include questions about malaria symptoms, self-treatment activities, and recent history of febrile illness. If the assessment suggests malaria, an evaluation should be done.

In Somalia, the use of contaminated water sources contributes to parasitic diseases. Up to 75% of the population may be affected by one or more intestinal parasites.⁶ In 1996,

54% of the Somali refugees entering Minnesota were screened, and of those, 55% were positive for parasites. Trichuris and Giardia were the most common parasites found.¹ Although some refugee camps screen and treat refugees for parasites, it is still important to include this screening in the domestic health assessment.

DOMESTIC HEALTH ASSESSMENT: TUBERCULOSIS

All refugees should be screened for TB during the domestic health assessment.³ Refugees 6 months of age and older should be given a Mantoux

Table 2

Domestic health assessment

Health history and physical examination	review the overseas records, interview refugee, and perform physical examination
Tuberculosis infection and disease	described in detail in next section
Hepatitis B infection	do screening panel and liver function tests to determine presence of carriers; provide education about reducing the risk of transmission and maintaining own health; identify and immunize household contacts of carriers
Immunization status	review and administer needed immunizations; refer to local source for completion of vaccines
Parasitic infections	collect stool samples to test for parasitic infections (some countries perform these tests during the overseas medical exam)
Anemia	perform blood tests to identify problem; follow-up testing to determine the cause
Pregnancy	identify pregnant women and link to appropriate prenatal care
Vision, hearing, and dental abnormalities	screen for gross abnormalities and refer as needed

skin test, regardless of BCG history. If the skin test is positive (greater than 10mm), a chest x-ray is done to determine the presence of active disease. A chest x-ray is also given to any refugee who:

- is classified as TB Class A or TB Class B during the immigration medical screening; or
- has symptoms compatible with TB disease⁴; or
- lives with someone with active infectious TB.

SOMALI REFUGEES AND TUBERCULOSIS IN HENNEPIN COUNTY

In 1996 the total number of tuberculosis cases in Minnesota was 131, of which 60% (78) occurred in foreign-born persons. Of those, 21 (27%) were Somali refugees or immigrants. The date of entry into the United States was known for 18 of the 21 patients. For 10 Somalis (48%), TB

was diagnosed within the first 12 months of arrival. The average time between date of entry and TB diagnosis was 22 months, with a range of one month to 52 months. Twelve cases (57%) were pulmonary TB. The remaining nine cases were extrapulmonary infections found in soft tissue, pleura, peritoneum, bone and joint, breast, and brain.⁷

Bacteriology cultures were performed on all cases of pulmonary TB in adults. Several patients had negative bacteriology but were diagnosed based on clinical and x-ray findings. In the 13 patients with positive cultures and for which drug susceptibility data were available, two had multidrug-resistant organisms and 11 had drug-sensitive organisms. All 21 patients were started on treatment. One patient died and another moved. The rest completed treatment or are still on medications and being monitored.⁷ In 1997 INH resistance was documented in three cases, INH and

streptomycin resistance in two cases, and streptomycin resistance in one case.

HEALTH ASSESSMENT AND PROMOTION CLINIC

The Health Assessment and Promotion Clinic at Hennepin County Community Health Department conducts refugee health screening and treats TB infection and disease. Many Somalis are seen and treated for TB at the clinic. Somali interpreters are available for patients, and community health workers provide outreach, including home visits, community education, and school follow-up.

An interview with Aden Guled, the community health worker and Somali interpreter for the clinic, provided some insight into providing care to Somali refugees:

"Some Somalis consider TB a 'bad' disease and think it is incurable. Many Somali patients find it hard to admit that they have TB, and they may deny it when asked. A better approach when initially interviewing a Somali patient may be to ask about symptoms of TB disease rather than identifying it by name."

Like many refugee populations, Somalis are not accustomed to follow-up visits to a health care provider or prolonged medication regimens. One of the primary roles of the health care provider is to educate Somali patients about treatment regimens and provide reassurance about the success of the treatment. Many Somali refugees cannot read or write, so the teaching must be done verbally. It is important to evaluate the need to establish a directly observed therapy (DOT) program to ensure completion of the TB therapy. When instructing the patient about future appointments, be specific about when to come back and why the return visit is important. Reinforce these instructions about return visits frequently. Transportation can be a deterrent to follow-up visits, so transportation options should be discussed. Be specific when giving directions for follow-up visits, medication regimens, and disease outcomes to ensure that the Somali refugee has a good understanding of the course of treatment.

Health Assessment in Refugee Populations: Recommendations

TUBERCULOSIS

- Be aware of the high incidence of TB in some refugee populations.
- Carefully screen refugees and immigrants for TB and provide follow-up for those identified with disease or infection.
- Be alert for extrapulmonary tuberculosis disease and initiate appropriate diagnostic and treatment plans.
- Evaluate the need for directly observed therapy for treatment of both disease and infection.

OTHER HEALTH ISSUES

- Complete the domestic health assessment and address other health issues, such as parasitic diseases and anemia.
- Provide an interpreter for the patient during the visit with the health care provider.
- Learn about the culture to avoid potential barriers to understanding.
- Clearly explain the diagnosis and treatment plan to the patient and make sure he or she understands (ask the patient to rephrase your words if an interpreter is not available).

Somali refugees face many challenges as they struggle to relocate and start anew. TB screening, diagnosis, and treatment are essential elements of the initial health assessment for this population.

RESOURCES

For Hennepin County residents, the Health Assessment and Promotion Clinic (612/348-3033) serves as a refugee screening site and gives Hennepin County health care providers information about current refugee health screening protocols and treatment of TB infection and disease. In addition, the MDH Refugee Health Program (612/623-5693) offers information and guidance to health care providers serving newly arrived refugees. The MDH TB Prevention and Control Program (612/623-5414) provides information about TB infection and disease. **MM**

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A Community Health Assessment of a Culturally Diverse Housing Project in St. Paul

Diana K. DuBois, M.P.H., M.I.A.

ABSTRACT

A comprehensive community needs assessment was recently completed at Skyline Towers, a culturally diverse housing project in St. Paul. Eighty-one randomly selected residents were interviewed over a one-month period. This article outlines the process of conducting the assessment and describes the results from the health care and demographic sections of the survey. The assessment showed that two-thirds of the building residents were born outside the United States and that the Somali population in particular faces linguistic, financial, and cultural barriers that limit their access to health care.

To the thousands of commuters who drive past on I-94 every day, Skyline Towers looks like just another high-rise apartment building. What few realize is that over 850 people from a dozen different countries call Skyline Towers home. More than 22 languages can be heard as you walk its halls. Some residents call Skyline Towers, located just west of Central Medical in St. Paul's Midway neighborhood, a mini United Nations. Most of the building's residents live in low-income households. A recent survey of Skyline residents highlighted some of the most pressing health concerns of this unique community.

Constructed over 20 years ago, the privately owned, publicly subsidized high-rise has 506 apartment units. Two-thirds of Skyline Towers residents were born outside of the United States, and approximately three-fourths of the residents receive a federal housing subsidy. Skyline Towers represents one of the greatest local concentrations of poverty in a single building. Yet these figures tell only part of the story. During the last few years, a remarkable coalition of groups has come together to improve health, education, and employment opportunities for people living in the building.

Many Skyline Towers residents face special challenges as low-income immigrants. Families may be disconnected from available neighborhood resources, or may feel unstable as they await family members from their home countries. Many single women with children and elderly residents are struggling financially. In addition, most residents encounter multiple cultural and linguistic barriers.

To help Skyline Towers residents improve their lives, a coalition of approximately 40 private, public, and

nonprofit agencies was formed in early 1996 under the aegis of Model Cities of St. Paul. The Skyline Towers Collaborative provides a network of services: child care, English language and citizenship classes, health care services, and a job bank.

THE SKYLINE TOWERS ASSESSMENT PROJECT

The Skyline Towers Assessment Project (STAP) began in early 1997 as a task force of the Skyline Towers Collaborative. The STAP committee was formed to assess residents' health, education, and employment needs. The committee also wanted to identify residents' unique talents and strengths.

STAP members* decided to conduct a comprehensive survey, which would allow residents to voice their opinions about a range of topics. The information gathered would be used by social service agencies, health care providers, and building management to better understand residents and their needs.

METHODS: ASSESSING A DIVERSE COMMUNITY

Given the diversity of cultures at Skyline Towers, assessing the needs and resources of the building's residents required a carefully planned

*The STAP committee included members from Regions Hospital, Model Cities of St. Paul, the Lexington-Hamline Community Council, the Tenants Action Council (from Skyline Towers), Minnesota International Health Volunteers, Sentinel Management (a private company that manages the building), Ramsey County Department of Human Services, St. Paul Rehabilitation Center, Karuna Childcare, and the St. Paul-Ramsey County Department of Public Health.

process that was sensitive to such factors as language, gender, lifestyle, and attitudes toward health. Before this survey was completed, there was very little reliable data about the building's population.

An initial community assessment survey was developed consisting of 97 questions broken down into the following categories: demographics, adult health, community improvement, immigration, children, education, and employment.

To build a profile of the Skyline Towers community, the project coordinator randomly selected 140 apartments (about 28% of the building's units). The demographic make-up of the building by country of origin was: Vietnam (31%), United States (29%), Somalia (17%), Ethiopia (9%), and the remaining residents (14%) from a variety of countries, including Liberia, Cuba, Sudan, Egypt, Eritrea, Germany, Sri Lanka, and Nigeria.

A pilot test of the survey was conducted with a cross section of community leaders in the building. The revised survey was then translated into Somali and Vietnamese, the two most common languages other than English spoken in the building.

Nine interviewers from a variety of backgrounds conducted the survey. The interviewers included six building residents and three people who live outside the building but are known and trusted by many residents. One-on-one interviews were conducted with 81 randomly selected residents of Skyline Towers over a one-month period in November and December 1997. Interviewees understood that no individual data would be reported and that their responses would be confidential. The average interview lasted 45 minutes.

The data were analyzed using an SPSS software package.

SELECTED RESULTS

Following are selected demographic and health care data from the survey. Information from the sections on immigration, employment, education, community involvement, and children is not included in this article but is provided in the complete sur-

vey report (see acknowledgments for more information).

ADULT HEALTH DATA

- Between 75% and 80% of the residents surveyed did not report problems with making a medical appointment, reading medical labels, getting medical insurance, understanding their medical insurance, understanding how to get to a clinic or doctor's office, or understanding how to find an interpreter. However, half the Somalis surveyed reported problems with those health concerns.

- Ninety-three percent of those surveyed reported that they had health insurance. (Approximately three-quarters of the residents surveyed receive some type of public assistance, which often provides health insurance coverage.)

- Forty percent of those surveyed had a HealthPartners care plan, 25% had UCare, 11% reported "other" health insurance, 10% had Medica, and 5% said they used BluePlus. Approximately 10% of those surveyed did not specify which type of health insurance they used.

- Eighty-two percent of the residents surveyed reported having dental insurance. When analyzed by country of origin, the data showed that while the majority of Vietnamese residents (21 out of 24) visited the dentist at least once a year, only two of the 10 Somalis visited the dentist at least once a year. Four of the Somalis reported that they never saw a dentist.

- When residents get sick, they most often seek help from family and friends (32%), the clinic listed on their health card (31%), or the hospital emergency room (21%). Sixteen percent did not respond.

- When asked where they went to see a doctor or nurse, the majority of those surveyed identified Regions Hospital (54%). (This may be due to a variety of reasons: the proximity of Regions Hospital, recommendations by other residents in the building, or because the Center for International Health, which has interpreters on staff, is located there.)

- About one-third (32%) of the immigrant respondents said they needed an interpreter with them when

they visited a doctor or nurse. Of those, 55% used an interpreter provided by the clinic, 19% had an adult family member help them, another 19% did not have anyone to help them, and 7% used one of their children to interpret.

DEMOGRAPHICS

- The 81 residents interviewed came from these countries: Vietnam (24 people), United States (25), Somalia (16), Ethiopia (6), Eritrea (3), Sudan (3), Liberia (2), Nigeria (1), and Sri Lanka (1).

- Almost three-quarters (74%) of the residents surveyed were women. All the Somalis interviewed were women, 22 of the 24 U.S.-born residents were women, and half the Vietnamese interviewed were women. The high percentage of women surveyed likely reflects the high percentage of female-headed households in the building.

- The majority of residents surveyed (74%) receive some form of public assistance (either AFDC, General Assistance, Medical Assistance, Social Security, or WIC), and many residents use several types.

- Sixty-three percent of those surveyed were immigrants.

- The Somalis are the newest major immigrant group to settle in the building (all 16 Somalis who completed the survey have lived in the United States five years or less).

- Forty percent of the immigrants reported that they could speak no English or only a little.

DISCUSSION

While the assessment found that a relatively high percentage of Skyline Towers residents are covered by health and dental insurance, it also highlighted the particular challenges faced by the Somali population. Many Somali families in the building do not know how to make a medical appointment, read the label on medicines, or understand their medical insurance plans.

Two critical steps could be taken to assist the Somali community at Skyline Towers: 1) continue to ensure that the Somali population receives English language instruction (some are currently attending class-

es); and 2) provide Somalis with targeted health education. According to Ali Abdulkader of the Somali Community of Minnesota, the linguistic, financial, and cultural barriers that affect the Somali population in Skyline Towers are shared by many Somalis in the state, whose numbers may now reach as high as 12,000.

The faces of Minnesota are changing. As the population becomes more diverse, the medical community must work to break down the barriers to health care for immigrant communities. An important part of this task for health care providers and public health professionals is to carefully ascertain the perceived needs and strengths of the communities they serve.

The Skyline Towers Collaborative members are using the results from the community needs assessment to better understand the people who live in the building, to improve existing programs, and to guide the collaborative in future endeavors. Two public health students are already using the survey results to help them determine which health issues to focus on while they assist with English language classes. **MM**

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For a copy of the complete report on the survey, which includes all the data, please contact Johannes Bedecha, director of supportive housing at Skyline Towers, 612/645-2068.

Diana DuBois is a public health consultant with extensive international experience, including five years of work in Africa. She served as the project coordinator of the Skyline

Towers Assessment Project and worked as a consultant on this project with Minnesota International Health Volunteers.

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Barriers to Health Care for Immigrants and Nonimmigrants: A Comparative Study

Craig R. Garrett, M.D., F.A.C.P., Christa J. Treichel, Ph.D., and Patricia Ohmans, M.P.H.

ABSTRACT

A survey asked medical social workers and visiting public health nurses to identify health problems and to compare barriers to health care experienced by immigrants and nonimmigrants in the Twin Cities area.

Respondents considered infectious diseases a more significant problem for immigrants; they saw alcohol and chemical dependency as more problematic for nonimmigrants.

Survey respondents thought that both groups experienced many of the same logistical barriers, including inadequate insurance coverage, transportation, mental stress, time constraints, and distance to their health care facilities. They identified language barriers and the need for trained interpreters as barriers for immigrants only. The survey confirmed widely held assumptions that cultural barriers are more problematic for immigrants, although these barriers were also perceived for nonimmigrants. Participants identified 16 of 18 health services as more available for nonimmigrants. Emergency and obstetrical services are equally available to the two groups, according to survey respondents.

In 1996 we published the results of interviews with 24 health care providers regarding their perceptions of cultural barriers to health care for refugees and immigrants.¹ The interviewees provided a broad range of professional services to immigrants in the Twin Cities area and were asked to respond to a list of 10 possible barriers to health care that immigrants might face. Respondents cited logistical barriers, such as poor transportation, limited access to interpreters, and lack of insurance, as well as culturally based barriers to health care.

The comments in the survey were instructive and insightful, but respondents' professional commitment to specific refugee and immigrant communities created a major bias. We decided to survey health care professionals who provide services to both immigrant and nonimmigrant patients to identify differences and similarities in health care barriers for both groups. We hoped this approach would correct the bias created in the previous study, further delineate barriers to care, and suggest areas for further study.

METHODS

STUDY PARTICIPANTS

Social workers and public nursing staff working in the Minneapolis/St. Paul metropolitan area were selected as survey respondents for several reasons. Most significantly, they deal frequently with both immigrant and nonimmigrant patients and their families, and they are reasonably familiar with community and social services for both target groups.

We chose two different types of health care professionals for the study: medical social workers at Hennepin County Medical Center and St. Paul-

Ramsey Medical Center (now Regions Hospital) and visiting nurses employed through the Metropolitan Visiting Nurses Association in Hennepin County.

SURVEY

Following a pilot test, we developed a self-administered survey that asked participants background questions and asked them to identify the five most common health problems immigrants and nonimmigrants face. We grouped individual responses by organ system for ease of comparison. Respondents then commented on the availability of services, potential logistical barriers to health care, and possible cultural barriers for both immigrants and nonimmigrants. We used a five-point Likert scale and calculated the mean score for use in comparing groups.

STATISTICAL METHODS

We used the chi-square test to compare categories and used the t-test of means to determine significance of differences for the Likert scale questions. A statistical difference of $\leq .05$ was significant.

RESULTS

Fifty-eight individuals completed the survey. Eighty-five percent were female; 91% were European American, with the remainder evenly divided between African American, Native American, and Asian American. The average age of respondents was 42.5 years. Over 50% had completed at least some post-high school study, and only 2% had not completed high school. Most of those surveyed listed their job title as either social worker (55%) or public health nurse (36%). An Indian advocate, case aide, and home health aide coordinator also completed the survey. All responses

were included in the analysis.

The 15 categories of health problems grouped by organ systems for immigrant and nonimmigrant communities are listed in Table 1. Individual health problems were grouped for ease of comparison; for example, hepatitis was included in infectious diseases. There were 166 responses for immigrants and 169 for nonimmigrants. The only significant differences in identified problem areas were infectious diseases for immigrants and alcohol and chemical abuse for nonimmigrants. Tuberculosis was the most commonly mentioned infectious disease for immigrants, followed by parasites and hepatitis. For nonimmigrants, tuberculosis was only mentioned once and parasites not at all.

The survey asked about six *logistical* barriers that both immigrants and nonimmigrants might face in accessing Western-style health care. As noted in Table 2, a lack of trained interpreters was the only logistical barrier that was significantly different between the groups.

In contrast, seven of 11 potential *cultural* barriers were significantly different between immigrants and nonimmigrants. These cultural barriers were rated as more significant for immigrants than for nonimmigrants, as shown in Table 3.

Table 4 lists 18 health services, all of which were rated as more available for nonimmigrants, except for access to emergency and trauma services and obstetrical services; respondents considered these equally available to both groups.

DISCUSSION

The survey results point out a surprising number of areas in which both immigrants and nonimmigrants were viewed as facing similar health care challenges, with a few significant differences.

HEALTH PROBLEMS

Infectious diseases, particularly parasitic diseases and tuberculosis, were seen as much more of a problem for immigrants than for nonimmigrants. In 1996, 453 of 1,059 new refugees to Minnesota (43%) had at least one parasite. For the same year, 421 of

Table 1

Health areas identified as significant problems

Health Areas	Immigrants n (%)	Nonimmigrant n (%)
1. Mental health	17 (10.2)	13 (7.7)
2. Head and neck	0 (0.0)	1 (0.6)
3. Respiratory	15 (9.0)	18 (10.6)
4. Cardiovascular	14 (8.4)	17 (10.1)
5. Gastrointestinal	1 (6.6)	9 (5.3)
6. Genitourinary	4 (2.4)	5 (3.0)
7. Pregnancy related	24 (14.5)	21 (12.4)
8. Joint/trauma	14 (8.4)	23 (13.6)
9. Infectious diseases*	57 (34.3)	17 (10.1)
10. Abuse	2 (1.2)	4 (2.4)
11. Skin problems	1 (0.6)	0 (0.0)
12. Blood/cancer	5 (3.0)	7 (4.1)
13. Alcohol/chemical abuse*	2 (1.2)	14 (8.3)
14. Endocrine problems	4 (2.4)	9 (5.3)
15. Neurology	6 (3.6)	11 (6.5)
	166	169

*Significant difference at 5% level by chi-square analysis of proportions

Table 2

*Potential logistical barriers for immigrants and nonimmigrants**

Barrier	Immigrant patients	Nonimmigrant patients
1. Insurance coverage/costs	1.54	1.69
2. Transportation	1.52	1.76
3. Distance to facility	2.11	2.13
4. Time commitments to family/work	1.93	1.96
5. Language/trained interpreters	1.37	3.42 [†]
6. Mental stress/dysfunction	1.96	2.07

*Expressed as a mean of listed choices from 1, "very significant," to 4, "insignificant." A rating of 5 indicated that the respondent was "unsure" about the significance of the barrier.

[†]p < 0.05

1,190 (35%) were found to have a positive (>10 mm) Mantoux skin test.² (See related article, page 43.) Zuber et al. noted that the incident rate of *Mycobacterium tuberculosis* among foreign-born persons in the United States was four times the rate of the U.S.-born population from 1986 to 1994. Since 55% of the

tuberculosis cases among foreign-born persons had been diagnosed less than five years after the immigrants' arrival in the United States, it appears that imported tuberculosis (active or latent) is responsible for most cases of tuberculosis among immigrants in the United States.³ These data lend support to our survey participants'

Table 3

*Potential cultural barriers for immigrants and nonimmigrants**

Barrier	Immigrant patients	Nonimmigrant patients
1. Gender issues	2.09	2.62 [†]
2. Class issues	2.31	2.48
3. Age issues	2.55	2.81
4. Intrusive/invasive procedure	2.04	2.77 [†]
5. Beliefs about diseases	1.83	2.58 [†]
6. Association of providers with government/police	2.58	2.83
7. Harm of treatment outweighing	2.19	2.25
8. Nonrecognition of medical need by provider or patient	1.96	2.35 [†]
9. Lack of acknowledgment of family systems	2.00	2.69 [†]
10. Providers seen as alien/distant	1.88	2.37 [†]
11. Stigma or shame over health condition	2.19	2.61 [†]

*Expressed as a mean of listed choices from 1, "very significant," to 4, "insignificant." A rating of 5 indicated that the respondent was "unsure" about the significance of the barrier.

[†]p < 0.05

responses.

Both tuberculosis and parasites are amenable to chemotherapy. Heightened awareness of the high incidence rates for these diseases in immigrants should lead to earlier diagnosis and treatment. Early treatment should reduce the health risk posed to both immigrant and nonimmigrant communities.

While respondents identified infectious diseases as a problem for immigrants, they believed that nonimmigrants had more problems with alcohol or chemical abuse. One might suspect, however, that substance abuse might increase among certain segments of the immigrant population as they become acculturated over time.

LOGISTICAL BARRIERS

Survey participants identified many of the same barriers to health care for immigrants and nonimmigrants. As indicated in Table 2, cost, transportation, distance, and other factors

were important to both groups; only language or the need for trained interpreters were significantly different. When working with immigrants, health planners should consider that logistical barriers are perceived as slightly more difficult for immigrants.

CULTURAL BARRIERS

A number of cultural barriers appear to be accentuated in the immigrant population, a finding that supports the need for cultural competence and awareness among health care providers.

An immigrant health care task force of the Minnesota Public Health Association recently published a report outlining six steps for improving cultural competence.⁴ These steps include involving immigrants in their own health care; learning more about cultures; speaking the language or using a trained interpreter; asking the right questions and looking for answers; paying attention to finan-

cial issues; and finding resources and forming partnerships.

Four cultural barriers were not deemed significant in our study, perhaps because there were too few respondents to reach a statistical difference or because these barriers pertain only to certain immigrant populations. Survey participants may have had a bias or expectation that immigrants would be more sensitive to cultural barriers. Clearly, they felt that nonimmigrant patients also experience cultural barriers (see Table 3).

AVAILABILITY OF CARE

Study participants thought that most clinical and related social services were less available for immigrants than for nonimmigrants. It is unclear why respondents felt that two services, emergency or trauma services and obstetric services, were equally available to immigrants.

Surprisingly, social services were rated as less available to immigrants than to nonimmigrants. This is especially interesting since many respondents were social workers who worked with immigrants. Even traditional healers appeared to be more available to nonimmigrants than to immigrants; the reason for this perception is unclear. Whether immigrants themselves would agree with this rating is also unknown.

LIMITATIONS

There are a number of limitations to this study. First, the survey studied perceptions rather than quantitative measures. While a social worker may believe that an immigrant faces certain barriers or has certain health problems, a review of the medical record or an interview with the immigrant may not support that view.

Second, the survey posed questions about immigrants and nonimmigrants in general. Some findings may have changed if questions had referred to particular ethnic groups, genders, or ages, for example. Third, not everyone asked completed the study. Those who completed the study may differ from those who declined to participate. Fourth, the study may not have been large enough to identify significant differences.

Finally, the results may not be

Table 4

*Perceived availability of services**

Services	Immigrant patients	Nonimmigrant patients
1. Chemical dependency	2.95	1.60 [†]
2. Counseling	2.61	1.64 [†]
3. Dental	2.54	1.89 [†]
4. Skin problems	2.44	2.09 [†]
5. Emergency/trauma	1.50	1.21
6. Family planning	2.39	1.64 [†]
7. General medical	1.74	1.33 [†]
8. Gynecological	1.93	1.58 [†]
9. Home care	2.20	1.70 [†]
10. Immunization	2.09	1.62 [†]
11. Obstetric	1.93	1.71
12. Pain management	3.02	2.42 [†]
13. Palliative/hospice	3.28	2.23 [†]
14. Pediatric	2.02	1.84 [†]
15. Psychiatric	2.85	1.87 [†]
16. Screening/health promotion	2.31	1.76 [†]
17. Social services	1.96	1.45 [†]
18. Traditional healers	3.33	2.91 [†]

*Expressed as a mean of listed choices from 1, "very available," to 4, "unavailable." A rating of 5 indicated that the respondent was "unsure" about the availability of the service.

[†]p < 0.05

applicable to other areas of the state or country, which have different health care systems. It is unclear how recent welfare reforms will affect health care availability or barriers to health care for both immigrants and nonimmigrants.

Potential areas for further study might include a survey of immigrant and nonimmigrant attitudes, a review of medical records to identify health problems in each group, and a comparative examination of the use of different services in various health care facilities.

CONCLUSION

In summary, survey participants described few differences in health problems between immigrants and nonimmigrants. However, they considered infectious diseases a more significant problem for immigrants,

while viewing alcohol and chemical dependency as more of a problem for nonimmigrants. Language or the need for trained interpreters was the only significant logistical barrier they identified for immigrants. As anticipated, respondents perceived many but not all potential cultural barriers to be more important for immigrants than nonimmigrants. Finally, they perceived nearly all health care services to be less available to immigrants.

Given the findings of this study, health care institutions should be alert to certain infectious diseases within the immigrant population, provide trained interpreters, understand the cultural barriers to health care, and improve access to all health-related services.

MM

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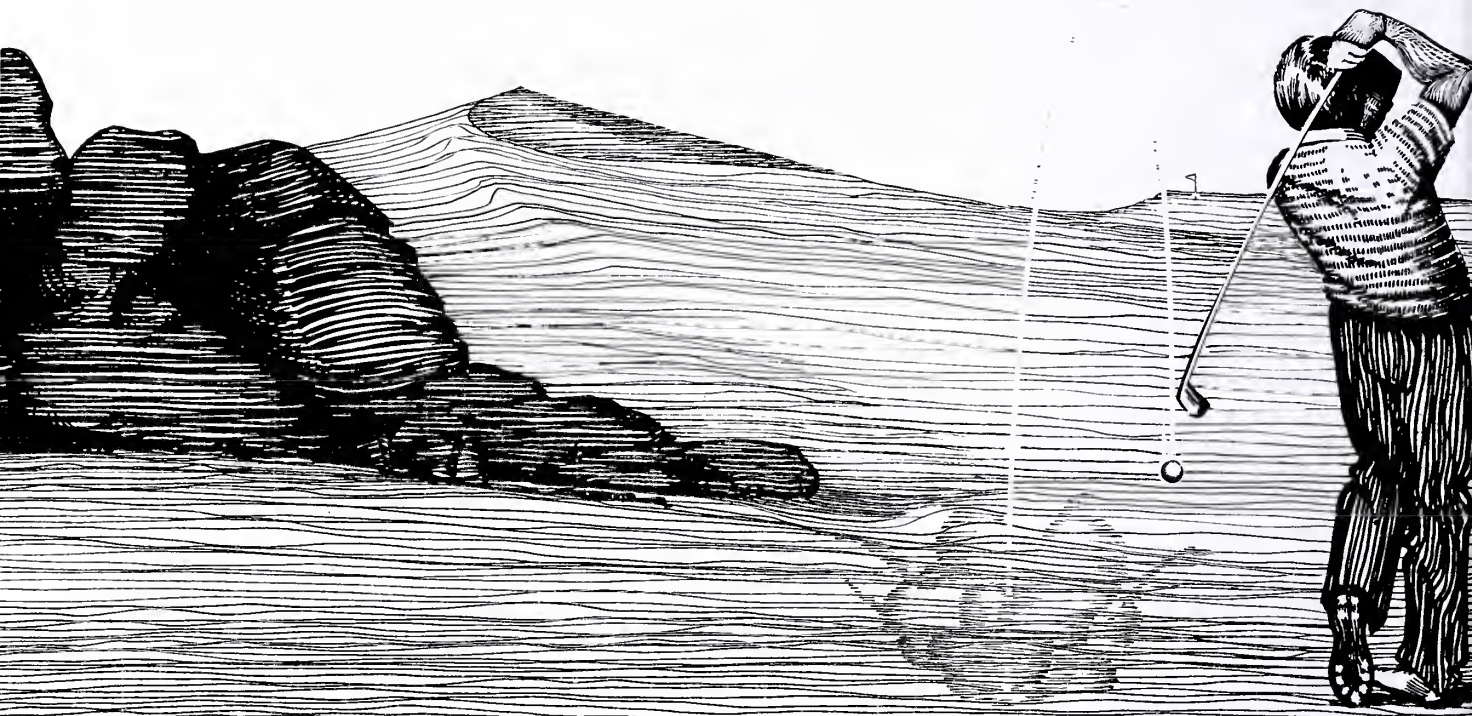
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Childhood Lead Poisoning

In response to the CDC's new childhood lead poisoning guidelines, the Minnesota Department of Health is developing a statewide screening plan.

Myron Falken, Ph.D., M.P.H., and Dianne Kocourek Ploetz, B.S.

Editor's Note: *This is the first in a series of articles on childhood lead poisoning written by the Minnesota Department of Health. The article provides background information about childhood lead poisoning and our understanding of the problem in Minnesota, and it describes the recently released CDC guidelines on childhood blood lead screening. Future articles will present information regarding the progress in developing Minnesota-specific screening guidelines. Don't assume that lead screening and toxicity are someone else's problem.*

—Barbara Yawn, M.D., M.Sc.,
Series Editor

In November 1997, the Centers for Disease Control and Prevention (CDC) released new screening guidelines for childhood lead poisoning in a document titled "Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials." The updated guidelines offer states, local health agencies, and health care providers recommendations for improving targeted blood lead screening services for young children—that is, screening children based on the presence of certain risk factors.

BACKGROUND

The CDC has identified childhood lead poisoning as the most common pediatric environmental health problem in the United States. Lead poisoning occurs in both adults and children, but children are at greater risk; young children are more likely to eat nonfood items and put their hands in their mouths, and they may absorb up to 40% to 50% of ingested lead. Lead's harmful effects on a child's developing nervous system have been identified at levels as low as 10 micrograms of lead per deciliter ($\mu\text{g}/\text{dL}$) of blood. Lead poisoning can cause learning, behavioral, and health problems. Blood lead levels of 70 $\mu\text{g}/\text{dL}$ or more can cause devastating health consequences, including seizures, coma, and death.

Children and adults are exposed to lead by inhaling or ingesting anything that contains lead. Once in the bloodstream, lead moves into the soft tissues (kidneys,

liver, bone marrow, and brain) and mineralizing tissues (bone and teeth). Mineralizing tissue contains about 95% of the total body burden of lead in adults. Single-exposure studies with adults show that lead has a half-life in blood of approximately 25 days. In contrast, lead stored in the nonlabile portion of bone has a half-life of more than 25 years. A person's blood lead level can fall back toward normal levels after a single exposure to lead; however, the total body lead burden may still be elevated.

In 1991 the CDC recommended universal blood lead screening for children under 6 years of age. This approach received limited support. A 1994 national survey showed that only about one-fourth of young children had been screened for lead. Only about one-third of poor children, who are at higher risk for lead exposure, had been screened.

SOURCES OF LEAD EXPOSURE

Lead is a naturally occurring element that has been used for thousands of years in creating durable products and materials. Since lead is ubiquitous in the environment today, all humans have lead in their bodies. Data from the National Health and Nutrition Examination Survey III (NHANES III) indicates that the geometric mean blood lead level for Americans aged 1 to 74 years declined from 12.8 $\mu\text{g}/\text{dL}$ in 1976 to 1980 to 2.9 $\mu\text{g}/\text{dL}$ in 1988 to 1991. Experts believe that the decline results from the removal of lead from gasoline, paint, food cans, and drinking water.

Today the most common source of lead exposure for young children is old, deteriorating paint and the dust that chalks off the paint. Paint chips and dust get on children's hands, toys, and baby bottles and then into their mouths. Household paints contained lead until 1978, and during the 1940s, paint with up to 50% lead was used extensively. About 75% of homes built before 1978 contain some lead-based paint; usually the older, underlying layers of paint contain the lead. The U.S. Department of Housing and Urban Development estimates that 3.8 million homes with young children have either nonintact lead-based paint or high levels of lead in the house dust. Lead can also

be found in drinking water and soil.

NHANES III reported that 4.4% of U.S. children aged 1 to 5 years—about 890,000 children—had blood lead levels equal to or greater than 10 µg/dL. The CDC recommends educational, medical, and/or environmental intervention if blood lead levels measure 10 µg/dL or greater. Minnesota law requires educational and environmental interventions at certain blood lead levels.

Minnesota Statutes, Sections 144.9501–144.9509, require health education and an inspection of the home when a pregnant woman has venous blood lead level of 10 µg/dL or greater. Health education for the parents or guardians and a home inspection are required when a child under 6 years of age has a venous blood lead level of 15 µg/dL–19.9 µg/dL for 90 days or longer, or a blood lead level of 20 µg/dL or greater.

CHILDHOOD LEAD POISONING IN MINNESOTA

In 1996, 38,031 children newborn to 72 months were screened for lead in Minnesota. Almost 3,800 children (9.9%) had blood lead levels of ≥ 10 µg/dL; almost 350 (0.9%) had venous levels of ≥ 20 µg/dL. Since Minnesota law does not require blood lead testing, we do not know how many more children have lead poisoning but have never been screened.

The MDH is required by statute to maintain a surveillance system to monitor trends in blood lead levels in adults and children in Minnesota. The surveillance system consists of blood analyses and demographic and laboratory information reported by independent laboratories and/or hospitals that service over 1,000 medical clinics, hospitals, and employer groups throughout the state. Unfortunately, the system cannot work optimally if high-risk children are never screened.

The MDH uses the information to identify populations at risk for lead poisoning and to develop appropriate outreach and intervention programs. This system is also used to identify young children and pregnant women with blood lead levels that require follow-up, which includes education and home inspection by the local or state health department.

THE CDC'S NEW GUIDELINES

The CDC's goal for the new blood lead screening guidelines is to have each state develop and promote a state-specific targeted screening program. Each state is encouraged to review local information, including blood lead surveillance data and housing data, and formulate a targeted screening program that will reach children at risk for lead poisoning. Children would be selected for testing on the basis of criteria provided by state or local health departments. Some criteria suggested by the CDC include:

- residence in a high-risk zip code area or neighborhood identified by blood-lead surveillance data and housing data from the U.S. Census Bureau;
- membership in a subpopulation that is at increased risk for lead exposure. (National data have shown that poor children; minority children; children who are exposed to lead in home remedies, cosmetics, and ceramic

ware; and children living with adults exposed to lead on the job are at increased risk for lead exposure.)

- responses to a personal risk questionnaire.

The MDH has begun developing a statewide screening plan that addresses the issues outlined in the new CDC guidelines. Until the new state guidelines are available, MDH recommends the following:

- Health care providers who are currently using a targeted approach to screen high-risk children for blood lead should continue to do so. They should consider the CDC's general methods to target screening, including evaluating housing and blood lead data and recognizing high-risk populations.
- Health care providers who screen children who receive Medical Assistance should continue to follow the Minnesota Department of Human Services screening requirements.
- Health care providers who are not currently screening children but want to begin a program should use the basic recommendations from the new CDC document to target screening, or contact the MDH for technical support.

In the next few months, the MDH will organize a committee to develop the Minnesota-specific blood lead screening guidelines. The committee will include health care providers, health plan representatives, local public health officials, MDH staff, and others. To become involved in the process, or to request a copy of the CDC's "Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials," contact Dianne Kocourek Ploetz at 612/215-0888. To receive a summary of the MDH 1996 blood lead data, call Marla Pruitt at 612/215-0874. Look for further updates in future issues of *Minnesota Medicine*. MM

Myron Falken is principal epidemiologist with the Minnesota Department of Health, Division of Environmental Health, Section of Environmental Surveillance and Assessment. Dianne Kocourek Ploetz is a health educator in the Indoor Air and Lead Unit of the Minnesota Department of Health. Her responsibilities include developing education materials and providing education and outreach.

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People and Places Making Medical News

People

MCHP Names New Chair, Chair-Elect

The Minnesota Council of Health Plans has named **Nancy J. Feldman** 1998 chair and **Andrew P. Czajkowski** chair-elect.

Feldman is chief executive officer of UCare Minnesota, a 60,000-member nonprofit HMO serving low-income and special-needs individuals.

Czajkowski is president and CEO of Blue Cross and Blue Shield of Minnesota and a member of the BCBSM Board of Trustees. He is also CEO of the company's subsidiary, MII, Inc.

Czajkowski recently received the Outstanding Achievement Award from the University of Minnesota. The award recognizes exceptional achievement by alumni in a professional field. He led the growth of BCBSM to 22 affiliated companies providing a range of managed care and insurance services under a nonprofit parent corporation, Aware Integrated Inc., of which he is CEO. He founded the Minnesota Comprehensive Health Association, the state-administered risk pool for individuals unable to qualify for private health coverage, and served as president and board chair from 1976 to 1982.

HealthPartners Gives Awards for Excellence

HealthPartners honored several physicians and dentists with awards for excellent performance. The Dr. Maurice Visscher Award for overall clinical excellence went to **Leonard Snellman, M.D.**, a pediatrician at the HealthPartners White Bear Lake Clinic; **Robert Olson, M.D.**, head of the gastroenterology section at Regions Hospital; and **James Gowan, D.D.S.**, who practices at the

HealthPartners St. Paul Dental Clinic. **Elie Gertner, M.D.**, chief of the rheumatology section at Regions Hospital, earned the Mulhausen Award for excellence in teaching and graduate medical education. **Keith Henry, M.D.**, director of the AIDS/HIV programs at Regions Hospital, received the Research Award for extraordinary achievement in clinical research.

HealthSystem Minnesota Names Chief Operating Officer

David Wessner, executive vice president of HealthSystem Minnesota, is now the organization's chief operating officer. As executive vice president and COO, Wessner oversees operations relating to patient care and corporate services.

Places

New Clinics Offer Alternative Health Care

HealthPartners began offering alternative health therapies, including massage, chiropractic care, and acupuncture, at clinics in Inver Grove Heights and Uptown Minneapolis last month. The effort is a pilot program that will be reviewed throughout the year.

In February, the Asian Community Health Center opened an alternative medicine center in the Frogtown neighborhood of St. Paul. The center aims to serve St. Paul's growing Southeast Asian population and offers a primary care doctor as well as acupuncture, herbal remedies, and tai chi.

Socioeconomics

HealthEast to Keep St. Joseph's Open

Responding to pressure from doctors and community leaders, HealthEast reversed its plans to close St. Joseph's Hospital in

downtown St. Paul, which had been targeted for closure by 2000. When it announced its decision in 1996, HealthEast said the number of patients at the 220-bed hospital, the state's oldest, was declining. Since then, the company said, a number of factors changed, including the collapse of a partnership with Allina's United Hospital, strong community and business support, and a turnaround in patient numbers, prompted by the closure of Midway Hospital last year.

HealthEast doctors and community members also objected strenuously to the plan to close St. Joseph's. "Physicians and the community have told us in no uncertain terms that they want a HealthEast presence in downtown St. Paul," said **Ann Schrader**, HealthEast vice president for patient care delivery systems, in a *Star Tribune* article.

HealthEast said the decision would not affect its plans to build a 70-bed hospital and clinic in Woodbury. That campus, called Woodwinds, also will include a clinic in partnership with Children's Hospitals and Clinics.

The 1,500 workers at St. Joseph's will keep their jobs for now, but some downsizing is likely after the Woodbury hospital opens in 2000, said Schrader. "At this point, St. Joseph's is doing great," she told the *Saint Paul Pioneer Press*. "It has a good number of patients, good staff, good doctors. That's what we're meant to be."

HealthPartners Will Not Bid to Renew BHCAG Contract

HealthPartners announced last month it will not submit a bid to renew its contract to administer the Buyers Health Care Action Group (BHCAG) health insurance program after the contract expires on December 31, 1999. In an article in the *Saint Paul Pioneer Press*,

HealthPartners CEO George Halvorson said, "We told them that we've been happy working with them the past five years, and we will continue to deliver the same high-quality service for the next 22 months of our contract, but after that we're done."

He said the management goals of BHCAG, a coalition of more than 25 of Minnesota's largest employers, conflict with HealthPartners' ideas about running a plan. In addition, he said, BHCAG is evolving into a "virtual health plan," contracting with doctors, clinics, and hospitals on its own. "We welcome the Action Group to the marketplace as a competitor."

Steve Wetzell, executive director of BHCAG, said he does not see the organization as a competitor to HMOs. Rather, BHCAG wants to increase competition in the marketplace even more. The coalition formed in 1992 to counter the growing power of managed care organizations.

HealthPartners' contract with BHCAG amounts to about \$15 million a year in revenue. Halvorson said the 300 HealthPartners employees who administer the BHCAG contract are not likely to be affected. A spokesperson for BHCAG said covered employees will be able to get care from the same clinics, doctors, and hospitals after the administrative change.

Express Scripts Buys ValueRx

ValueRx, a pharmaceutical benefits management firm headquartered in Plymouth, Minnesota, will be sold to Express Scripts Inc., of St. Louis, for \$445 million in cash, both companies announced in February. ValueRx will keep its name and most of its 800 staff positions, but Chief Executive Kevin Roberg and senior managers will leave the company. Roberg and his management team had made a bid on the company to take it independent.

Both ValueRx and Express Scripts help clients control prescription drug costs through bulk purchasing and by developing

formularies. ValueRx, with estimated annual revenues of \$1.5 billion, serves employer groups and indemnity insurance carriers. Express Scripts, with 1997 revenues of \$1.2 billion, serves managed care plans and companies that administer health benefits for self-insured employers.

Columbia/HCA Healthcare controlled ValueRx for about a year but put it on the auction block when the hospital chain became the object of a federal investigation into Medicare fraud.

Consumers Choose Low-Cost Clinics, BHCAG Report Shows

A report released by the Buyers Health Care Action Group shows that lower-cost clinic groups available to members experienced the most significant enrollment gains after last fall's open enrollment period, with increases ranging from 15 percent to 57 percent. High-cost clinics saw enrollment shrink, except for one clinic that had a high quality rating. BHCAG members who choose a low-cost care system pay no additional premium, but those who choose mid-cost or high-cost systems pay additional premiums ranging from about \$8.50 to \$19 a month for an individual. At the same time, employees of the companies who make up BHCAG are provided with survey results ranking the quality of clinics.

Steve Wetzell, BHCAG executive director, said he was encouraged that consumers are taking price and quality into consideration. Some physician groups that contract with BHCAG, however, expressed concern about the validity of the consumer satisfaction data used by BHCAG.

HealthPartners, BCBSM Will Cover Stop-Smoking Aids

Blue Cross and Blue Shield of Minnesota and HealthPartners announced they will cover the cost of prescription treatments to quit smoking, including nicotine gum, nicotine patches, and the anti-depressant drug Zyban. Last

December Medica announced a similar policy change.

With these new policies, the three health insurers that cover 80 percent of Minnesota residents will pay for smoking-cessation treatments. However, the benefit change will apply only to members in fully insured health plans. Those in self-insured plans, about 40 percent of the state's population, won't be eligible unless their employers choose to provide them.

"There is very recent scientific information that supports the medical and cost-effectiveness of smoking-cessation products," said Sanne Magnan, M.D., associate medical director of Blue Plus, the HMO arm of Blue Cross, in a *Star Tribune* article. HealthPartners spokesperson Sara McFee said, "We have decided that smoking-cessation products will be a good value for some members who need tools to help them quit."

HealthPartners will begin to phase in the benefits in July. Blue Cross members will see the change in September.

Citizens Forum on Health Care Calls for Consumer Assistance

With public anxiety building about rapid changes in the health care industry, a group of legislators, citizens, and health professionals called for more assistance to worried consumers. At the Minnesota Citizens Forum on February 7, the group, which included state Health Commissioner Anne Barry, Sen. Paul Wellstone, and Steve Wetzell, executive director of the Buyers Health Care Action Group, discussed the future of medicine in Minnesota. Executives from the major health plans in the state and other participants said they support legislation that would create a new state office to handle consumer complaints.

Sen. Wellstone also pledged federal help. He said he plans to introduce legislation in Congress that will provide new consumer protections. But, he said, "I'm not here to bash managed care. Managed care can be good or bad,

depending on who is doing the managing."

The meeting, sponsored by the *Star Tribune* and KTCA-TV, was organized in response to a series of *Star Tribune* articles last year about the spread of managed care in the state.

Rates, Trends, Data

Racial Gap Seen in Health Measures

While the health of white Minnesotans improved from 1980 to 1990, gains among Minnesotans of color, particularly African Americans and American Indians, have either lagged behind or gotten worse. Health outcomes are becoming more segregated, according to Mike Christenson, executive director of the Allina Foundation, the charitable funding arm of the state's largest HMO.

Reports by the Office of Minority Health in the Minnesota Department of Health, a community advisory committee, and the Urban Coalition detail the problems and challenge state health officials, health plans, and health professionals to find ways to close the gap.

The statistics reported by the groups show that from late adolescence until age 65, African Americans and American Indians in Minnesota were two to three times more likely to die than members of other racial groups. Infant mortality rates for whites and Asians fell from 10 to 6 per 1,000 babies, but that of American Indians increased from 14 to 16. Although African-American infant deaths fell from 23 to 17 per 1,000 babies, the 26 percent improvement lagged behind the 40 percent improvement that whites and Asians experienced.

The Allina Foundation announced a \$1 million grant program for community groups to develop new ways to solve the problem or determine what existing ways work better than others.

Pertussis Diagnoses Rise

The number of reported cases of pertussis, or whooping cough, is rising in Minnesota, and physicians are realizing the disease is more common in teens and adults than previously thought, said state

Health Department officials and researchers at HealthPartners. Last year, 518 cases were reported in Minnesota, the highest number since 1955, according to preliminary figures from the Health Department.

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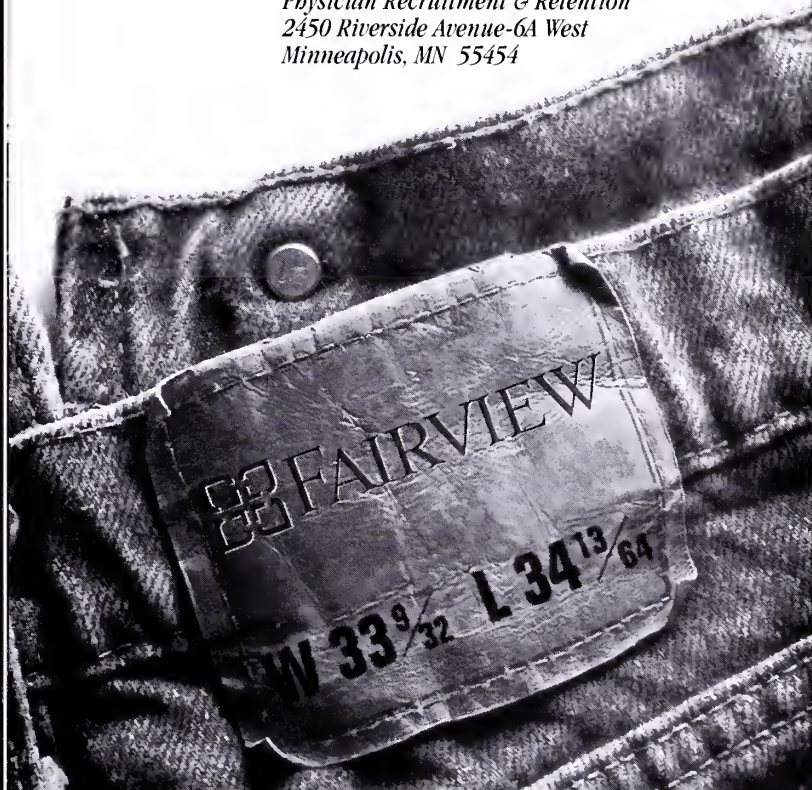
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A small study of HealthPartners patients in the Twin Cities found evidence of whooping cough in one of four teenagers and preteens who had coughs lasting one to four weeks. All of them had been vaccinated as young children, said James Nordin, M.D., a HealthPartners pediatrician who conducted the study for the Centers for Disease Control and Prevention. He and state epidemiologists agree that the disease itself is probably not more prevalent, but the number of cases diagnosed has risen as physicians become more aware of the risk of whooping cough among older children and adults.

Medical Research

Study Links Alcohol Use to Risk of Breast Cancer

Women who consume two to five alcoholic drinks a day have a 41 percent higher risk of developing breast cancer than women who don't drink, according to researchers at the University of Minnesota and elsewhere. The breast cancer risk for women who drink from three-fourths to one drink a day is 9 percent higher.

"Drinking alcohol moderately increases the risk of breast cancer, so women should consider their use of alcohol if they are trying to avoid breast cancer," said Aaron Folsom, M.P.H., a professor of epidemiology at the university and one of the researchers, in a *Star Tribune* article. He also pointed out that light drinkers tend to have lower overall mortality rates than nondrinkers, so he does not recommend that women avoid alcohol altogether.

The study, which pooled the data gathered from 322,647 women from four nations, confirms the findings of dozens of smaller studies.

Drug Works for Men with Enlarged Prostates

The controversial drug Proscar reduces the need for surgery or emergency treatment by more than

50 percent in men whose prostate glands have become abnormally enlarged by benign prostatic disease, researchers at the Mayo Clinic and elsewhere have found. The study, published in the February 26 *New England Journal of Medicine*, offers men another treatment option.

Proscar works only on men with abnormally enlarged prostates, said Michael Lieber, M.D., a professor of urology at the Mayo Clinic. Men with smaller prostates can be treated with other drugs—Hytrin, Cardura, and Flomax. Proscar physically shrinks the prostate by up to 30 percent, Lieber said, which opens the urethra and allows urine to flow more easily.

Bacteria in Mouth May Contribute to Heart Attacks

Bacteria commonly found in dental plaque may trigger the blood clots that cause heart attacks, report researchers at the University of Minnesota. The finding may explain why so many heart attacks happen in the morning, when people brush their teeth, releasing the bacteria into the bloodstream. The researchers postulate that the bacteria may cause blood clots that can clog already narrowed coronary arteries, triggering myocardial infarction.

In a study presented at the American Association for the Advancement of Science meeting in February, Mark Herzberg, D.D.S., M.S., Ph.D., and his colleagues showed that *Streptococcus sanguis*, common in the human mouth, can trigger blood clots in the coronary arteries of rabbits.

"We have no evidence whatsoever that this process ... occurs in people," Herzberg, a dentist, biochemist, and professor of preventive services in the university's School of Dentistry, told the *Saint Paul Pioneer Press*. "But there is growing circumstantial evidence that dental infections are independent risk factors for heart attacks."

The link between heart attacks

and such dental conditions as periodontitis and tooth abscesses was first reported in 1989 by a cardiologist in Helsinki, Finland, who observed that an unusually high number of his heart attack patients also had bad teeth. Since then, several studies have suggested that dental infections are a risk factor for heart attacks.

Mayo Researchers Discover Genes Linked to MS

Researchers at the Mayo Clinic have discovered a family of genes that cause the neurological damage found in patients with multiple sclerosis. This finding should lead to more effective treatments, the researchers say. In the study, reported in the February issue of *Nature Medicine*, researchers injected a virus into genetically identical mice to trigger MS. One group of mice developed the classic symptoms of MS, while the other group remained free of symptoms, even though they had the disease. Using gene mapping techniques, the researchers were able to identify a family of genes that determined whether the disease would damage nerve fibers.

Childhood Leukemia Study Shows Benefits of Chemotherapy

Intensive chemotherapy treatments in children with one type of leukemia, t(1:19) acute lymphoblastic leukemia, doubles their survival rate, from 40 percent to 80 percent, according to a study conducted in part by researchers at the Wayne Hughes Institute in Roseville, the University of Minnesota in Minneapolis, and the Mayo Clinic in Rochester. The study involved 1,322 children and was conducted by researchers in the 120 centers that belong to the Children's Cancer Group. The results were published in the February *Journal of Clinical Oncology*. MM

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

A P R I L 1 9 9 8

Apr. 16-17 **Critical Care 1998** Critical Care Department at Regions Hospital and HealthPartners Institute for Medical Education; Holiday Inn East, St. Paul, MN. CONTACT: Sharon Kopp, HealthPartners Institute for Medical Education, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Apr. 16-18 **Fractures and Dislocations of the Wrist, Elbow, and Shoulder** Mayo Foundation; Pointe Hilton Resort on South Mountain, Phoenix, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 17 **Depression and Mood Disorders: Treating Today's Woman** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

Apr. 17 **14th Annual Heart Conference** St. Mary's/Duluth Clinic Health System; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Diane Torvick, 400 East Third Street, Maildrop 5AV2ME, Duluth, MN 55805; 218/725-3838.

Apr. 17-18 **Youth and Sports: Contemporary Issues for the Primary Care Physician** Children's Health Care; Madden's Resort, Brainerd, MN. CONTACT: Betsy Julius, Medical Education, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-5884.

Apr. 23-24 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 24-25 **Neuroscience Summit: What's New Today and Looking to the Tomorrows** St. Luke's Hospital and Regional Trauma Center; Holiday Inn, Duluth, MN. CONTACT: Cheryl Jurek, Education Department, 915 East First Street, Duluth, MN 55805; 218/726-5449.

M A Y 1 9 9 8

May 5-8 **Fifth International Surgical Pathology Symposium** Mayo Medical Laboratories; Munich, Germany. CONTACT:

Kathy Bates, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; E-mail: Kbates@mayo.edu; 507/282-0461.

May 13 **Principles of Diabetes Management: Basics & Trends** United Hospital Diabetes Center; United Hospital,

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

April 17-18 **North Central Chapter of the Infectious Diseases Society of America** Mayo Clinic; Radisson Plaza Hotel Minneapolis, Minneapolis, MN. CONTACT: Mary Majerus, Mayo Clinic, Division of Clinical Microbiology-Hilton 470, 200 First Street SW, Rochester, MN 55905; 507/284-3021.

May. 8 **Emerging Infections in Clinical Practice** University of Minnesota; Minneapolis Airport Marriott, Bloomington, MN. CONTACT: Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 29-30 **The Prescription: A Latex Safe Environment 'Stop the Sensitization'** Allina Health System; The Northland Inn, Brooklyn Park, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

June 23 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

E N D U R I N G M A T E R I A L S

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Julie Page, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

St. Paul, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 15 **Medical Management of the Surgical Patient** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 15-16 **John I. Coe Symposium and Minnesota Society of Pathologists Meeting** Hennepin County Medical Center; Radisson Hotel South, Bloomington, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 15 & May 22 **Advanced Cardiac Life Support (ACLS)** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 21 **Advanced Diabetes Management: Complications & Trends** United Hospital Diabetes Center; United Hospital, St. Paul, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 22 **Poisonous Mushrooms** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC

CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 30 **Critical Care: A Team Approach** Mayo Foundation; Mayo Clinic, Phillips Hall, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

JUNE 1998

June 4-6 **Fifth Annual Mayo Interventional Cardiology Symposium** Mayo Foundation; Leighton Auditorium, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 17-20 **62nd Annual Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota Medical School Department of Surgery; Willey Hall, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 800/776-8636.

JULY 1998

July 16-18 **Management Strategies in Hematologic Oncology** Mayo Medical Laboratories; Ihilani Resort and Spa,

Central Lakes Medical Center Crosby, Minnesota

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Kapolei, Oahu, HI. CONTACT: Kathy Bates, 200 First Street SW, Rochester, MN 55905; 507/284-3942.

July 29-31 **Mayo Multidisciplinary Symposium on Platelets, Blood Vessels, and Extracorporeal Medicine** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

AUGUST 1998

August 3-5 **Allina Primary Care Update: Health Risk Assessment and Preventive Care** Allina Health System; Cragun's Conference Center, Brainerd, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, P.O. Box 9310, Minneapolis, MN 55440; 612/992-3897.

August 5 & August 12 **Advanced Cardiac Life Support (ACLS)** Allina Health System; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

August 9-11 **Success with Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Chateau Whistler, Whistler, British Columbia, Canada. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

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This is a modern, well-equipped facility that serves the Red Lake Band of Chippewa Indians as well as the rural community. The emergency room sees approximately 19,000 annual visits; however, they are primarily clinic visits; only 750 annual visits are emergent. Trauma is transferred to Bemidji. We are seeking a medical director and full and part time staff physicians for this emergency department team. We will provide relocation assistance if needed.

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MAY, 1998

13 PRINCIPLES OF DIABETES

MANAGEMENT: *Basics & Trends*

Presented by: United Hospital Diabetes Center

Location: United Hospital, St. Paul

15 & 22 ADVANCED CARDIAC LIFE SUPPORT

Presented by: Allina Health System

Location: United Hospital, St. Paul

21 ADVANCED DIABETES MANAGEMENT:

Complications and Trends

Presented by: United Hospital Diabetes Center

Location: United Hospital, St. Paul

29-30 The Prescription: A LATEX SAFE ENVIRONMENT

Presented by: Allina Health System and ELASTIC, Inc.

Location: The Northland Inn, Brooklyn Park

AUGUST, 1998

3-5 ALLINA HEALTH SYSTEM '98 PRIMARY CARE CONFERENCE

Presented by: Allina Health System

Location: Cragun's Conference Center, Brainerd

For more information, contact Allina Clinical Education and Research - (612) 992-2424

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Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: occupational medicine, dermatology, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

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MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Physician Opportunity: Minneapolis/St. Paul, Duluth, and Moorhead, Minnesota; MD wanted for part-time hours in multidisciplinary office. All inquiries to Integrated Health-Care Services, doctor's private line, 612/386-6908. (1/98-R)

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e mail: recruit@allina.com

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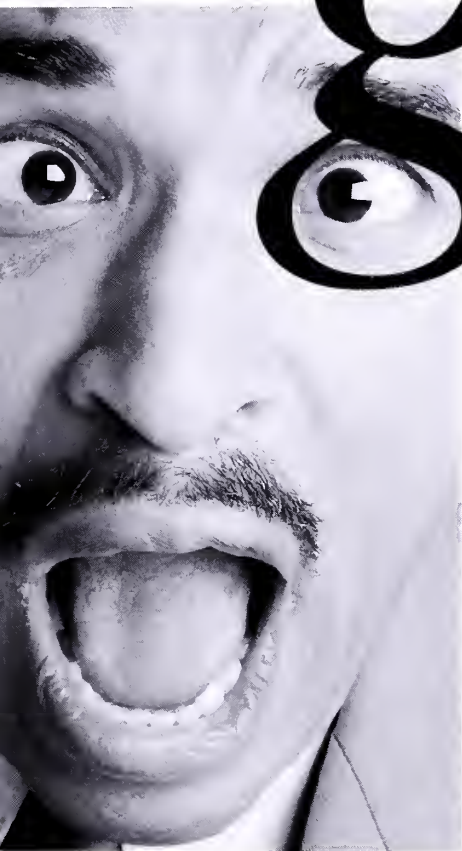


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COVER

The Salmonella bacterium is one of the culprits sought by Minnesota Health Department epidemiologists in their battle against foodborne illnesses. Photograph © Science Source, Photo Researchers, Inc.

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Epidemiology: Beyond the Numbers

The monthly publication physicians get from the Minnesota Department of Health includes a lot of numbers—tallies of AIDS, salmonellosis, smokers under 18, deaths by drowning. Although it's sumptuous dessert for statisticians, it may seem like wastebasket liner or scientific soporific for some readers. Yet those numbers have galactic implications. They mold present and future medical practice. They drive legislation. They influence billions of dollars. And they can inflame or calm public fear. Here's what



.....
"Epidemiologic numbers have galactic implications. They mold medical practice, drive legislation, influence billions of dollars, and they can inflame or calm public fear."

I learned about epidemiology and epidemiologists while working on this month's *Minnesota Medicine*:

- Epidemiologists thrive on detail. While most of us develop bilateral ptosis when patients begin describing their lunch, epidemiologists investigating the Schwan's ice cream epidemic made the diagnosis by tirelessly probing victims' diets (see the Cover Story, page 18).

- Epidemiologists trust statistics. Practicing physicians have to hedge their statistics since clinical medicine is inexact. The public has to settle for "abouts" for much of their medical information. But before one positive culture came back, the epidemiologists in the Schwan's case fingered ice cream as the culprit based purely on the power of numbers—the number of victims who had eaten Schwan's.

- Epidemiologists are potentially powerful people who may be "guardians of our public health," as our Cover Story calls them, or snoopers into private matters, depending on your fears or prejudices.

- Epidemiology identifies disease as it's happening. The epidemiological community frequently gives emerging infectious diseases or resistant infections their first public explication (see our Clinical & Health Affairs articles, pages 25 and 30).

- Epidemiology tells us what medicine has done well—Russell Luepker's Special Report (page 47) details the decline of cardiovascular mortality—and about the burden of our success. The same decline has resulted in people surviving their first MI only to pop up later with even costlier CHF or another MI. It also tells us what we're not doing so well, like controlling adolescent smoking and detecting untreated hypertension.

- Epidemiology pinpoints the culprits that make spread of disease more explosive, like huge tanker trucks carrying *Salmonella*-tainted raw eggs.

- Epidemiology provides scientific footing for medical care, legislative mandates, public opinion, and legal battles. Experts in different arenas arrive at belief at different times and with different criteria for proof. Mandel and Oken's Special Report on cancer (page 44) summarizes recommendations on fecal occult blood and mammogram screening widely accepted in the medical community. Yet Medicare doesn't cover these procedures according to recommendations. The authors cite lack of proof of efficacy for PSA screening. Yet the man on the street insists it's necessary.

- Epidemiology can soothe or stir public fear. Howard Markel's book, "Quarantine: East European Jewish Immigrants and the New York City Epidemics of 1892," describes the NYC Health Department's simultaneous battle with typhus, cholera, and New Yorkers' ethnic scapegoating and benighted fears of disease. We need the epidemiologist's scientific perspective to quell similar fears about AIDS, radiation, and pollutants.

Mark Twain once said statistics are one level worse than "lies and damned lies." W.H. Auden worried about the inhumanity of numbers:

*Out of the air a voice without a face
 Proved by statistics that some cause
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Our society relies on epidemiology and epidemiologists to truthfully guide medicine with a scientific and a human face.

.....
 —Charles R. Meyer, M.D., Editor-in-Chief

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Epidemiology in Minnesota

Introduction to *Minnesota Medicine's* Special Issue on
Epidemiology by David Parker, M.D., M.P.H., Guest Editor

The heroes of epidemiology are well-known to the public through such suspenseful thrillers as "Outbreak," "The Hot Zone," and "Level 4: Virus Hunters of the CDC." Beyond the headline-garnering work of infectious disease epidemiologists, a legion of researchers from other areas of the field quietly go about studying everything from injuries to cancer to environmental hazards such as air pollution and PCBs in fish. Epidemiology is woven into the fabric of medicine and plays an increasingly important role in health care delivery.

The "bug busters" have come a long way since John Snow traced the source of a London cholera epidemic in 1854. Epidemiologists no longer look just at food- and waterborne illness. The field has become so specialized that neuroepidemiology, pharmacoepidemiology, occupational epidemiology, and cardiovascular epidemiology are just a few areas of exploration. As physicians look to epidemiology to provide guidance in delivering health care, communities turn to this field to solve the riddles of their health problems.

This special issue of *Minnesota Medicine* begins with a profile of Leonard Kurland, M.D., Dr.P.H., one of the state's first epidemiologists. In an article about the role of epidemiology in investigating cancer clusters, Allan Williams, Ph.D., M.P.H., points to a critical component of both epidemiology and public health: disease surveillance. To evaluate disease rates, we need to compile accurate information. This is true for sexually transmitted diseases, cancers, or work-related amputations. Limits on our ability to collect that information threaten both public health and medical research. Alan Bender, D.V.M., Ph.D., discusses how changing perceptions of public institu-

tions and information technology could undermine sound public health and medical epidemiology. "Historically, public health and medicine have not had to compete for public favor and acceptance," Bender writes. "This is new ground not of our choosing. ... Are we ready for the challenge?"

In other articles, David Williams, M.B., Ch.B., explains why it is crucial for physicians to curb overuse of antibiotics as part of the effort to reverse the alarming increase in drug-resistant strains of pathogenic bacteria. Richard Danila, Ph.D., M.P.H., provides an update on HIV and AIDS in Minnesota, and attorney Mark Friedlander Jr. summarizes legal uses of epidemiologic data. Finally, to give some suggestion of the breadth and variety of epidemiologic work going on in Minnesota, we invited several researchers to contribute short articles about their areas of expertise. This is not an exhaustive survey—missing, for example, are reports on tick-borne disease and nutrition epidemiology. Any oversights are not intentional—we could have filled several *Minnesota Medicine* issues on the topic.

We hope that this issue provides an interesting and informative view of epidemiology in Minnesota. Preserving medical research and the public health infrastructure will require a careful balance of informed consent and mandatory disease reporting as we strive to promote the public good and individual rights. **MM**

David Parker is an occupational epidemiologist at the Minnesota Department of Health and a physician at Park Nicollet Medical Center/HealthSystem Minnesota. He served as guest editor for this issue of Minnesota Medicine.

At the Epicenter

By Ralph Heussner • Photo by John Noltner

Calling Leonard T. Kurland, M.D., Dr.P.H., a pioneer in epidemiology might be an understatement. Consider his accomplishments: He initiated the Rochester Epidemiology Project, which has spawned more than 1,000 studies of almost every major disease; he's authored more than 530 articles in medical journals and books; for nearly four decades, he doggedly pursued answers to the "Guam Riddle"—why islanders

develop serious neurologic disease in unprecedented numbers; he's served on a dozen government panels, studying perplexing medical issues such as the impact of swine flu, Agent Orange, the Love Canal, contaminants in the food supply, and post-polio syndrome. ("They tend to call whenever there's a panic situation," Kurland says.)

Although the soft-spoken 76-year-old scientist officially retired as professor and chair of the Mayo Clinic Department of Medical Statistics and Epidemiology in 1995, he spends most afternoons in a Mayo office answering medical correspondence, reviewing journal articles, or pondering his next epidemiological challenge. "The department always has at least 30 good studies in the queue," says Kurland.

A Serendipitous Career Start

Kurland grew up in Baltimore, where he received his undergraduate degree from Johns Hopkins University and earned a medical degree from the University of Maryland in 1945. After an internship at Maryland University Hospital, he served a residency at the Glenn Dale Tuberculosis Sanatorium.

Kurland turned his focus to preventive medicine ("where I thought I could be most useful") and entered the U.S. Public Health Service in 1946. At the same time, he pursued a master's degree at the Harvard School of Public Health. Within a few weeks of completing his thesis—a literature review of multiple sclerosis—Kurland's worldview of the neurological disease took a tailspin.

"Over the Christmas holiday of 1948, I was traveling home to Baltimore from Boston when I

stopped in New York for a medical meeting at the Roosevelt Hotel," Kurland recalls. "The third paper presented that day was by Alex MacLean and colleagues Henry Woltman and Joseph Berkson at the Mayo Clinic. They described multiple sclerosis in the population of a small, urban community."

According to Kurland, for the first time, the Mayo authors had shown conclusive long-term incidence rates as well as prevalence. Multiple sclerosis in Rochester was at least twice as high as reported anywhere else in the world and, incredibly, the median survival in Rochester was 35 years; the textbooks indicated it was only 10 to 12 years, based on hospitalized patients.

"There was a buzz in the audience from people around me who reacted with some disbelief," Kurland says. "Well, it was obvious to me that they had the data. In effect, my dissertation was torn apart, but it had an electrifying effect on me."

Speaking with MacLean afterward, Kurland learned that Mayo Clinic offered a tremendous resource of information using a unique patient indexing system first introduced by Henry Plummer, M.D., in 1907 and later refined by Berkson in 1935. "Our chance meeting at the Roosevelt Hotel changed my career," Kurland says.

A few weeks later, serendipity struck again. While visiting the National Institutes of Health (NIH), Kurland met Larry Kolb, M.D., who was interested in designing a national study of multiple sclerosis (Kolb later joined the Mayo staff). "I was surprised when they offered me the job of directing that study," Kurland says. "All of a sudden, my plan, based on my

master's thesis, became the national plan for the study of multiple sclerosis epidemiology in the United States and Canada."

Kurland spent the next three years conducting population-based studies of multiple sclerosis in Winnipeg, Manitoba, and New Orleans. Study results clearly documented a geographical pattern of the disease. The risk of multiple sclerosis was six times higher in Winnipeg than New Orleans.

Following a neurology residency at Mayo Clinic, Kurland became chief of the epidemiology branch of the National Institute of Neurological Disease and Blindness in 1955 and served in that capacity until retiring from the Public Health Service in 1964, when he joined the Mayo Clinic staff.

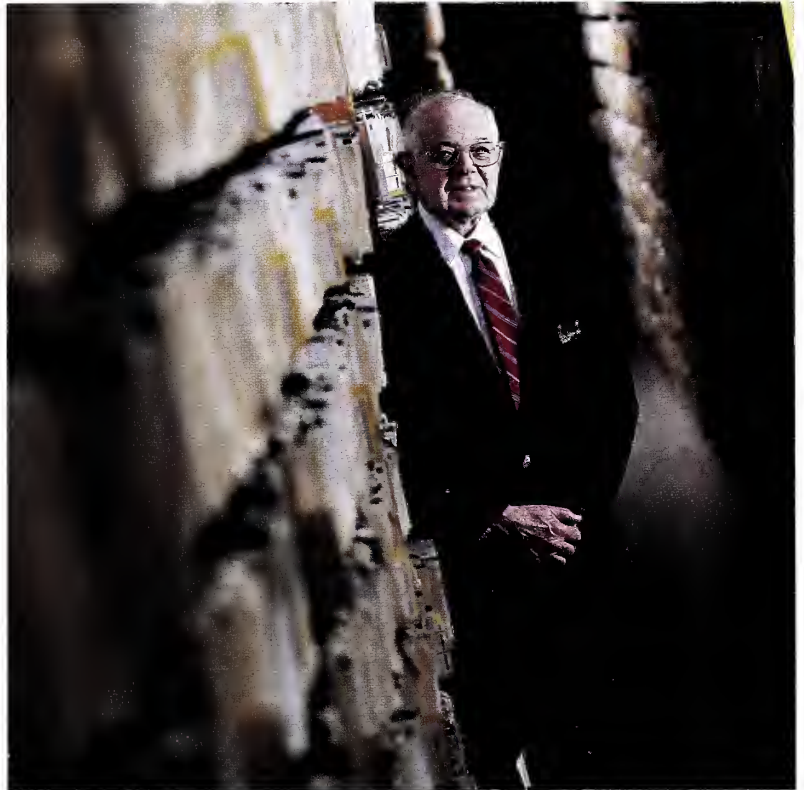
The Guam Riddle

Since the end of World War II, dozens of eminent scientists have struggled to solve a medical mystery on the western Pacific island of Guam. Why are native Guamanians at least

50 times more likely to suffer amyotrophic lateral sclerosis (ALS) or another major neurological disorder than someone living in Rochester, Minnesota?

The importance of solving the riddle is obvious. "If we can understand the disease mechanism in the patients on Guam, the same or a similar mechanism may be found for neurodegenerative diseases elsewhere," Kurland says.

Kurland first became involved with this puzzling problem in 1953 as a young neurology resident and public health officer. He and colleague Donald Mulder, M.D., then in the U.S. Navy and later a member of the Mayo staff, were among the first to document the incredible prevalence of ALS in Guam. They identified that the village of Umatac, near the island's southern end (and where Magellan landed in 1521 on his voyage around the world), had the highest prevalence rate—making it a sort of ground zero for the epidemic. Kurland and Mulder also documented that Guamanians suffered in unusually large numbers from Parkinson's disease and dementia, a condition



Dr. Leonard Kurland applied Mayo's unique, highly detailed record system devised by Dr. Henry Plummer in 1907 to epidemiological research and teaching.

they described as "parkinsonism-dementia complex."

Kurland and Mulder were the first to advance a theory of causality. They suggested that a slow toxin whose effects appear years after exposure causes the diseases. The chief suspect remains the cycad, a tropical palm-like tree whose seeds are used to prepare fadang, an important food source on Guam for more than 200 years. At least one substance in the cycad seeds may have a toxic effect on the brain, studies have shown.

The cycad seed hypothesis has swung in and out of favor with scientists over the past four decades. Other theories abound. Some scientists have suggested that excessive aluminum exposure, a slow-acting virus, or mineral deficiencies cause the neurological problems.

But Kurland continues to champion his theory. In his final progress report to the NIH in 1996, he suggested that the cycad toxin's entry into the body—oral ingestion, absorption from skin lesions, or nasal passage exposure—may affect disease manifesta-

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tion. "I think we are on the threshold of the solution," says Kurland. "I certainly hope the research will continue."

The Rochester Epidemiology Project

Kurland is best known in the scientific world for organizing and shepherding the Rochester Epidemiology Project, which built upon the early work of Mayo's Plummer and Berkson. The project, funded by the NIH since 1966, merges all medical records since 1935 of residents in Olmsted County—including patients at Mayo Clinic, the Olmsted Medical Center, plus smaller group and private medical practices—into a single database. "This is an incredible resource," Kurland says. "There's none other like it in the world."

The Rochester Epidemiology Project has generated seminal studies on the risk of leukemia due to diagnostic x-rays (there's no increased risk); the prevalence of herpes zoster, infant crib deaths, and mental retardation; the risk of stroke from birth control pills (there's no greater danger); and, recently, the rate of medical complications in women who receive silicone breast implants.

One of the more important studies examined the long-term consequences of using the synthetic estrogen hormone diethylstilbestrol (DES). In the 1940s and 1950s DES was widely prescribed during pregnancy to prevent possible miscarriage. In 1971, a case-control study from Boston reported an elevated rate of vaginal clear-cell cancer in young women who had been exposed to DES in the womb. But one of the study's shortcomings was lack of baseline incidence data for the population at large or among women exposed to DES.

When Mayo researchers looked into their medical information time vault, they did not find a single case of clear-cell cancer among 1,000 women exposed to DES in the womb. A follow-up multicenter study put the risk at one in 3,000. "Our study was reassuring to hundreds of thousands of women," Kurland says.

In examining patient records, the Mayo group found tremendous variation in dosing of DES. Boston women received DES in doses that were 12 times higher than the average dose of DES given in Rochester.

A few years later, the Rochester database became a key resource in the national immunization program against the swine flu strain of influenza. Physicians began observing a relatively large number of cases of Guillain-Barré syndrome paralysis among those who had been inoculated (see also the Medicine Law & Policy article, page 62). In order to determine how many cases constitute a relatively large number, it was necessary to know the baseline incidence of the disease.

Fortunately, the facts were close at hand—thanks to a 1973 population-based study of the Guillain-Barré syndrome in Olmsted County. According to the Mayo study, there was no increase in incidence of paralytic syndrome among swine flu immunization recipients.

Nevertheless, federal health officials halted the nationwide immunization campaign in December 1976; a swine flu epidemic never materialized.

Kurland's Legacy

Kurland and his wife, Miriam, have five children: Geoffrey, Steven, Robert, Keith, and Ellen. Kurland's legacy also includes his former students who've gone on to be leaders in neuroepidemiology. He exudes pride when recounting how many of them are now heads of clinical and scientific departments at major medical institutions throughout the country. "All of my students were sensitive and talented," he says. "I only helped bring their success to fruition."

Kurland says the next generation of medical sleuths faces new challenges. "My successors are taking our studies well beyond the science alone," he says. "They are looking at the efficiency of treatments, the cost-benefit ratio. They will provide answers to questions we weren't asking."

MM

Ralph Heussner is a managing editor in the Information Division of Mayo Medical Ventures.

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PUBLIC HEALTH PROTECTION *vs.* INFORMED CONSENT

Many epidemiologists are alarmed about laws requiring patients' consent to use their medical records. Challenging these restrictive policies requires us to confront major societal changes.

By Alan P. Bender, D.V.M., Ph.D.

Recent changes in Minnesota law¹ require epidemiologists, medical researchers, and other health professionals to obtain explicit permission from patients before their medical records may be used for medical research. Historically, medical institutions could release health records to qualified investigators for the purposes of medical or scientific research, if the patient did not specifically object to that use. Usually, the release of information from medical records was governed by Institutional Review Boards (IRBs) or similar bodies that evaluated the request. The potential medical significance of the investigation or research was weighed against the patient's right to privacy. If the potential gain outweighed the risk, the IRB generally granted access to the data. Access was controlled, however, so that the information was used only for the authorized purpose and to prevent further loss of privacy.

Many physicians and scientists have become alarmed that this law—and more important, the philosophy that led to the public policy—threatens medical research and, therefore, Minnesotans' well-being. Data from patients' medical records have been extremely important to many types of observational research, such as epidemiologic, prognostic, and treatment efficacy studies.

Legislative Background

The Minnesota Department of Health (MDH) currently has legal authority, conferred by the Minnesota Legislature, to collect, without consent, information on individuals who have one of more than 75 diseases, ranging from anthrax to cancer, mumps, spinal cord injuries, syphilis, typhus, and yellow fever. The use of this information varies depending on the condition. Physicians, scientists, policymakers, and community representatives worked extensively to develop the rationale for mandated reporting of specific diseases. Many of these specific reporting issues generated more than a year of intense debate and consensus building in public forums. The policies that legally require reporting of certain medical conditions for public health protection are now under scrutiny.

In the 1997 legislative session, two public health initiatives failed in part because the MDH would not

agree to provisions requiring the MDH to obtain consent of the individual (or parent) before specific medical information was reported to the department. Although the 1998 legislative session was not over at the time of this writing, the Senate had passed an amendment to the Occupational Respiratory Disease Information System bill, stipulating that information released to the commissioner of health must not contain individually identifiable information, without prior voluntary written consent from the patient.

The MDH believes that this policy is ill-founded and turns back the clock on well-established principles of public health protection. MDH representatives recently met with legislators to discuss the implications of and public concerns about informed consent and disease surveillance. We talked with over 50 legislators, mostly from the Health and Judiciary committees, where health and data practice policy are developed. These wide-ranging discussions gave us useful insights into the trend toward restricting access to medical records.

Public Lack of Trust in Institutions

The underlying issue in the debate over use of medical records is the public's lack of trust in institutions. Increasingly, the public distrusts all institutions—especially government and health care organizations. This distrust is coupled with a fear of emerging information technology, such as electronic databases of personal and medical data. These concerns have created a public demand for individual privacy.

Privacy is viewed as a foundation of personal freedom. Loss of control of medical information about oneself or one's family is seen as a loss of



ILLUSTRATION BY JOHN BERRY

freedom, resulting in fear, distrust, and outrage. Many legislators understand that people's fear and distrust are misdirected, but as politicians they must acknowledge public opinion. As one long-time MDH supporter said, "I agree with everything the MDH is saying about the negative consequences of these policies. But what the MDH must remember is that it is swimming upstream against public opinion. The MDH cannot compete with the negative messages being delivered by *Time*, *Newsweek*, and Joe Soucheray's radio talk show!" The implications are clear: unless the public changes its opinion, more restrictions will be placed on access to medical records—even for the purposes of medical research and public health protection.

Faulty Assumptions about Use of Data

Many legislators and the public have both warranted and unwarranted concerns about how the MDH uses and protects medical data. First, most legislators are unaware of the stringent protection the law provides these data and of the restrictions on their use. The data are better protected in the MDH than in individual medical records. Second, legislators believe that personal, sensitive medical information could easily be penetrated electronically by computer hackers. Lawmakers and the public are not aware of the attention and protections the MDH provides for personal medical data. Third, and most troubling, is the belief that government agencies, including the MDH, do not abide by legislative intent. That is, people fear that the MDH and other agencies will use private medical data for a variety of purposes, including allowing life, disability, medical, or other insurers access to the data. Unfortunately, well-publicized examples of irresponsible behavior by government agencies, especially at the federal level, have legitimized these fears.

It is a mistake to think that legislators who support these restrictions are against medical research or public health. Most or all of them strongly support the goals of improving medical care and public health. Many have conducted a cost-benefit analysis—the cost to individual privacy versus the benefits to society. Surprisingly, legislators who support the restrictions have *not* concluded that the cost to the individual outweighs the social benefit. Rather, they fervently believe that both goals can be accomplished at the same time—achieving important public health objectives while respecting the rights of those "few" individuals who would not want to release their medical data. The lawmakers are certain that if people understood how important the information was for

the health of their fellow citizens, "only a handful" would fail to give the required permission.

In our opinion, that assumption is doubtful and not supported by experience here and in other states. Realistically, a large number of people would not grant permission. This is because patients would have to make the decision in the physician's office, perhaps at a time of great emotional stress, without a complete understanding of how the information will be used to improve the public health, of the data's stringent legal protections, or of the deliberative process behind the request for this very personal data. In such settings, a substantial number of people would opt out of a voluntary "reporting" system.

The Lens of Personal Experience

Finally, most legislators filter public opinion through their own experiences. Many supporters of increased privacy protection cite an adverse medical encounter that crystallized their concerns. Their personal involvement carries an emotional component that cannot be swayed with objective data or expert testimony.

Diseases that legislators perceive as an immediate threat to themselves or their families are generally excluded from individual privacy concerns. Infectious diseases are viewed differently than chronic diseases, such as cancer or diabetes. Legislators intuitively understand the need to intervene in the natural history of communicable disease to protect themselves and the public. However, invading privacy to develop population-based data on cancer incidence, for example, is a very different matter. The threat is not immediate and the control measures appear distant at best. Therefore, access to data regarding noninfectious diseases is most threatened.

The Challenge for Medicine and Public Health

Simply describing the negative consequences of the restrictive policies is not enough. The problem of diminishing public trust must be addressed in an overall strategy to change these policies. One senior legislator said, "You just don't get it, do you?"—meaning that society and the Legislature are not the problem. Rather, the problem is a failure of the medical and public health communities to recognize major changes in societal attitudes. Medical and public health professionals must reestablish their credibility with the public and reconnect with policymakers.

Those of us who work in the public health and

medical communities cannot accept the premise that we should simply acquiesce to public opinion and get on with the business of adapting to more restrictive laws. We understand the significant negative consequences for public health and medical research that will follow. The challenge is to move from our current fragmented strategy to more productive approaches. This will clearly involve attempts to change the negative popular mood.

Solutions will not be easy. Making our case will require significant resources and energy. We must find a way to deliver the message that individual consent and public health protection are not both attainable. The benefits of collecting health information far outweigh the loss of privacy to the individual. The best strategy for delivering this message may be by helping people understand it on a personal level. We all at some time will be patients in search of a cure or specific information on treating a disease. We are all members of communities that require complete, accurate, up-to-date, population-based data to develop

meaningful public health and medical interventions for ourselves and our families. Hopefully, once the incompatibility of privacy and knowledge is understood, the prevailing mood will start to change.

Historically, public health and medicine have not had to seek public favor and acceptance. This is new ground not of our choosing. But this is where the battle will occur. The dominant disciplines in this battle will be public relations and education, not medicine or epidemiology. We must expand our vision and accept the fact that we are ill-trained and ill-prepared for this conflict. Are we ready for the challenge?

MM

Alan Bender is chief of the Section of Chronic Disease and Environmental Epidemiology at the Minnesota Department of Health.

REFERENCE

1. Minnesota Statutes 144.335.

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CANCER CLUSTERS

What Role for Epidemiology?

Epidemiology has an important role in addressing concerns about apparent cancer clusters—but that role is quite different from what the public expects.

By Allan N. Williams, M.P.H., Ph.D.

At last count, my bibliographic software listed over 300 references on “cancer clusters.” No doubt many other unpublished reports line the shelves of health departments around the country. The literature makes it clear that epidemiology’s role in addressing cancer clusters is uncertain and sometimes controversial.

My own awareness of cancer clusters started in graduate school during lectures on some early cluster investigations (such as Hodgkin’s disease among school contacts) and the statistical methodology involved. I was later given the “opportunity” to revisit this issue professionally by way of one of the unexpected—and often most frustrating—duties as a noninfectious disease epidemiologist at a state health department: responding to public concerns about apparent excesses of cancers. Over the past dozen years, the Minnesota Department of Health has received approximately 1,500 such calls.

These reports come from ordinary citizens, elected officials, teachers, public health officials, and physicians. The caller relates concerns about an apparently unusual number of cancers that have occurred in a community, neighborhood, office building, or school. The person usually assumes or fears that some insidious environmental exposure, such as an air or water pollutant, must be the common thread among the cases. Callers often expect that an epidemiologic investigation can and should be done and that

the causes of the cancers can be identified. That expectation is sometimes expressed in no uncertain terms: As one citizen put it, "If you would get off your bureaucratic ass and come out here and look around, maybe you'd find the causes of these diseases!"

The appropriate role of epidemiology in responding to these concerns has been the subject of extensive discussion, both in our own agency and nationally. In the early 1980s, Alan Bender, chief of Chronic Disease and Environmental Epidemiology at the Minnesota Department of Health, outlined a systematic public health response to reported cancer clusters. This protocol provided the conceptual model for many other state health departments. During the 1990s, the devel-

opment of Minnesota's statewide cancer registry, the increasing staff time required for cluster responses, and other considerations led to a reevaluation of our cluster response protocol, including the role of epidemiology.

Many years of experience, review of the literature, frequent discussions with colleagues around the country, and input from an ad hoc external advisory committee have yielded many insights into why concerns about cancer clusters continue to emerge and how epidemiology might be used—and misused—in addressing those concerns. I describe some of these issues here.

continued



ILLUSTRATION BY JOHN BERRY

Investigations Rarely Prove Useful

One aspect of epidemiology that has *not* proven useful in cluster situations in the community setting (i.e., nonindustrial environments) is full-scale epidemiologic studies (such as case-control studies), in which individuals are interviewed, medical records abstracted, and so forth. None of the criteria for good epidemiologic study design can be met in cluster situations. Most obviously, the sample size of any given "cluster" is woefully inadequate to detect a risk factor of reasonable magnitude. In many situations, it wouldn't be possible to identify risks as large as those from smoking or occupational exposure to asbestos. Just as important, random chance dictates that about one out of 20 comparisons will be "statistically significant," perhaps creating a concern where none is warranted. Epidemiologic investigations of geographic cancer clusters almost never provide etiologic insights into cancer.

Furthermore, conducting such a study uses scarce public health resources, invades personal privacy, and sends a misleading message to the community that these initiatives can provide useful scientific information. These studies cannot answer the underlying public concerns—what caused these cancers and how can we protect ourselves?

The Role of Epidemiology

INFORMATION AND EDUCATION

Nonetheless, epidemiology *can* be used in other ways to address cancer cluster concerns. Perhaps the most critical role for epidemiology is to provide education and information gleaned from thousands of studies over many decades. Most concerns about cancer arise from misconceptions about the natural history, causes, and prevalence of cancers. For example, to many members of the public, "cancer is cancer," as one concerned resident said at a public meeting discussing a cancer cluster in Arizona. To the medical and epidemiologic communities, cancer is not a single disease, but well over a hundred different diseases. Not only do the treatments and prognoses differ for different types of cancer, but the epidemiology is also different. Incidence rates, age distributions, trends, and risk factors vary from one cancer to another. Except for high doses of ionizing radiation and smoking, which are associated with many types of cancer, most known human carcinogens are associated with an increased risk of just one or perhaps two or three types of cancer. Consequently, a cluster that compris-

es several types of cancer (e.g., lung, breast, prostate, colon) would not have a single etiology. The great majority of reported excesses involve different types of cancer and are not considered actual clusters by epidemiologic definition.

IDENTIFYING CAUSES AND RISK FACTORS

Identifying the major causes or risk factors for cancer—particularly the role of "environmental" exposures—is another area in which epidemiologic findings are useful. Experts often state that most cancers are "environmental" in origin and thus potentially avoidable. "Environmental" does not refer only to ambient environmental exposures such as air and water pollutants. As used by most epidemiologists and clinicians, "environment" means everything that is not genetically inherited. It includes all aspects of a person's life and behavior, such as diet, smoking, occupational history, exposure to sunlight, reproductive history, viruses, medical history, alcohol use, and exposure to pollutants.

In this context, environmental factors do indeed account for most cancer occurrence. Cigarette smoking alone accounts for about one-third of the deaths from cancer in the United States. Diet accounts for a similar proportion. Occupational exposures to pollutants, which are typically many times higher than ambient environmental exposures, are estimated to cause about 5 percent of cancer deaths (mostly lung cancer). Although unknown, the contribution of ambient environmental pollutants to cancer must be quite small. Animal data suggest that risks from individual pollutants, even when unacceptable from a regulatory perspective, are much too small to be detected epidemiologically.

PERSPECTIVE ON INCIDENCE

Epidemiology can also provide perspective on the numbers of cancers that have occurred or can be expected to occur in a population. Cancer can be viewed as a rare or a common disease. If we're talking about the annual rate of occurrence of a specific type of cancer—particularly among people under age 50—cancer is relatively rare. However, the risk of developing some type of cancer at some time during the average life expectancy is great—almost one in two Minnesota residents will eventually be diagnosed with cancer. As people age, a previously rare disease becomes frighteningly common. Attending successive class or family reunions, people may notice that more and more friends and family members are getting

cancer. Statewide cancer incidence data showing the "expected" or actual number of cancers in a population over a period of time can provide needed perspective.

Clusters Are Not Unusual

Epidemiologic data also show that cancer clusters are not particularly rare. Innumerable clusters potentially could be recognized or "created" with the assistance of maps or software.

Clusters are often suspected when residents of a particular neighborhood become aware that a number of their neighbors have developed cancers during the past several months or years. The time frame and geographic boundaries are established based on knowledge of when and where the cases occurred. Clusters could be similarly identified by plotting all cancer cases on a map of a larger population, such as a county, and then drawing tight circles around aggregations of cases. This is a sort of gerrymandering: by choosing a geographic boundary and time frame in which the cases occurred—and ignoring adjacent areas and times when perhaps no cases occurred—a distorted and statistically uninterpretable situation is created. It is equivalent to drawing the bullseye on a target after the shots have already been fired. The possibilities for clusters can be further increased by including the years or time frame in which the greatest number of cases occurred. One can create innumerable and sometimes enormous excesses of cancer by imposing artificial boundaries around known cases.

An example of how this works can be seen using actual statewide cancer incidence data. Using county lines as geographic boundaries, excesses of cancer cases were identified for 85 types of cancer, for either sex, for any year between 1988 and 1994 in the 87 Minnesota counties. This analysis creates more than 100,000 possibilities for identifying an unusual cancer rate. Nearly 10,000 of these rates exceeded the statewide average by at least twofold. Roughly 1,500 of these rates reached the usual criteria of statistical significance.

If we were to repeat the same analysis for all the different neighborhoods, church groups, places of employment, school affiliations, and other groupings in the state, the number of potential elevations (or deficits) in cancer occurrences that might be seen is incalculable. Indeed, everyone is a member of many different groups based on residence, work, school, and social and religious affiliations. It is likely that one of these groupings has had or will have a rise in cancer occurrence over some block of time. The aging of the population and the increasing openness with which people discuss cancer contribute to greater recognition of such occurrences.

Epidemiology does have an extremely important role in addressing cancer clusters and cancer concerns. That role, however, is quite different from what many people expect. Full-scale epidemiologic studies of community cancer clusters have virtually never provided useful insights into the causes of cancer and are not likely to do so. Using existing epidemiologic data to provide education and perspective about the causes and frequency of cancer, however, is a vital and cost-effective role for epidemiology.

MM

Allan Williams is an epidemiologist with the Chronic Disease and Environmental Epidemiology Section of the Minnesota Department of Health.

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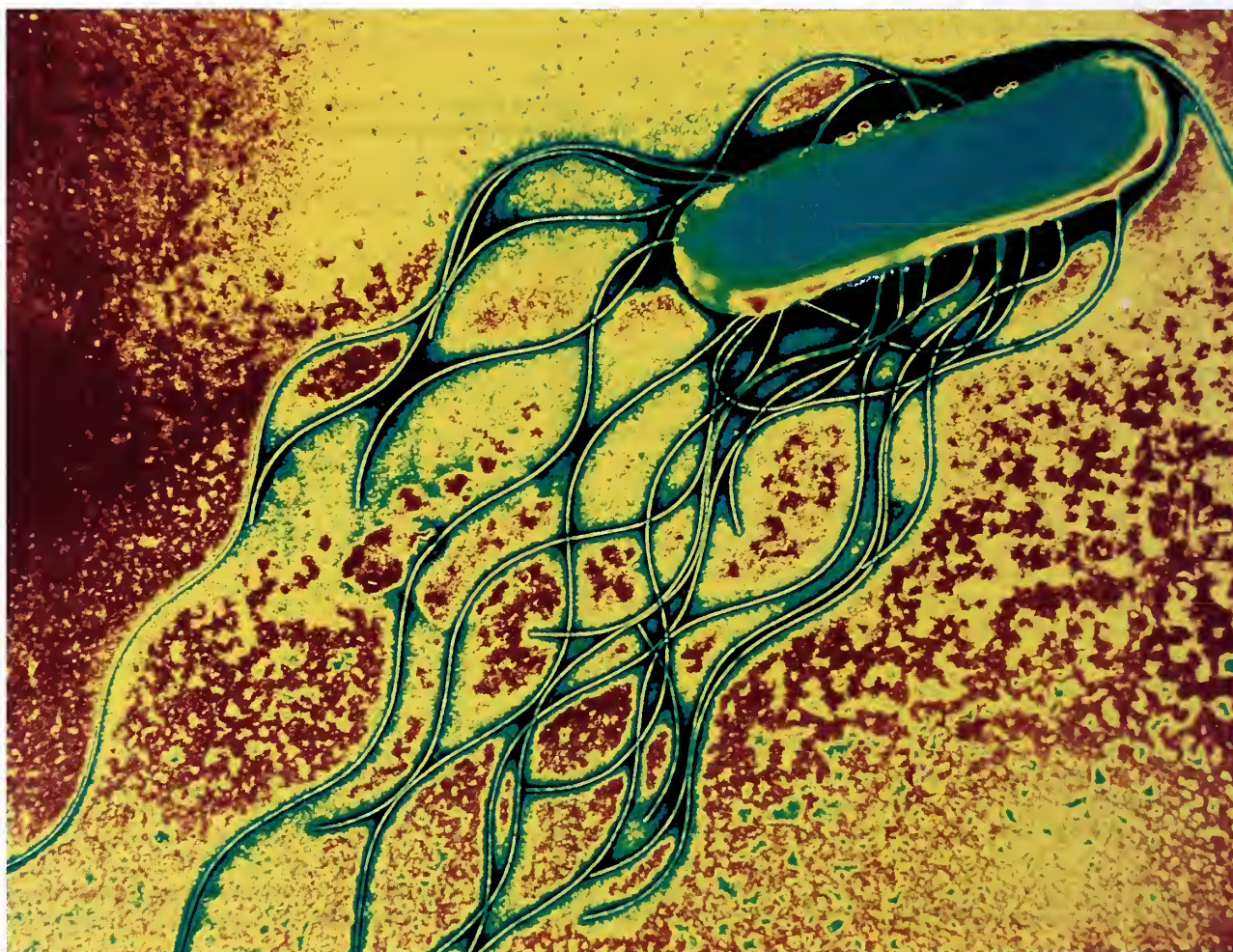
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Salmonella

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STERS

By Miriam Karmel Feldman

It all starts with a statistical blip. A slight upsurge in the numbers is all it takes to arouse the suspicion of the epidemiology team at the Minnesota Department of Health. One too many cases of a microorganism like *Cryptosporidium* or *Escherichia coli* O157:H7 will be detected and someone is likely to think—OUTBREAK. Can all of these cases be traced to a common source? If the upsurge is an outbreak, Minnesota's epidemiologists—world-renowned for their investigative prowess—are likely to crack the case.

One could say that the job of these public health guardians is to look for trouble. John Besser, M.S., who is a microbiologist by training, a medical detective at heart, puts it like this: "A lot of what you find is what you look for. By better understanding what's out there, we have the possibility of finding things wrong with our [food] delivery system."

Besser is supervisor of the microbiology lab that deals with bacterial, parasitic, and fungal diseases. But he also thinks of himself as a team player—one of a group of laboratorians and epidemiologists who spend their days (and sometimes nights) checking out hunches and tracking down leads based on statistical blips. He loves his work because there's a discovery to be made every day and because he believes these discoveries preserve our quality of life and protect the public health.

Besser's enthusiasm for his work is reassuring, considering how vulnerable we have become to emerging infectious diseases, those whose incidence in humans has increased within the past two decades or threatens to increase in the near future. In recent years,

alarming reports of foodborne illnesses and other diseases of infectious origin have awakened a public once lulled into complacency about matters of public health.

More than 400,000 people became ill in 1993, for example, from drinking contaminated tap water in Milwaukee. The culprit was an intestinal parasite, *Cryptosporidium*. That same year, more than 500 people became ill and four children died after eating undercooked hamburgers tainted with *E. coli* O157:H7 served at a fast-food chain.

Each year, an estimated 6 million to 81 million people in this country suffer from foodborne illness, defined as the occurrence of two or more cases of a similar illness resulting from ingesting a common food item. In Minnesota, according to state epidemiologist Michael Osterholm, Ph.D., M.P.H., an estimated 6.1 million cases of diarrheal illness affected the state's 4.4 million residents in a one-year period between 1996 and 1997 (though not all cases were related to contaminated foods).

This March, food safety was on the agenda of the first international meeting on new and emerging diseases, which drew some 2,500 participants from around the world. Osterholm was a featured speaker at the Atlanta meeting, which the Centers for Disease Control and Prevention (CDC) convened. According to a report in *The New York Times*, he challenged the safety of the U.S. food supply and said food safety problems may be getting worse. He then called for funding of state-of-the-art laboratories to detect known microbes and identify new ones. *continued*

PHYSICIANS PLAY A ROLE IN OUTBREAK DETECTION

An estimated 224,000 persons were affected in 1994 by the largest common-source outbreak of salmonellosis ever recognized in the United States. Yet only 593 of those cases were actually confirmed in the laboratory. In Minnesota, only 150 cases of the *Salmonella enteritidis* infections linked to Schwan's ice cream, or 0.5 percent of the estimated state's total, were reported to the Minnesota Department of Health.

"That shows you what a slim margin our surveillance of foodborne disease operates on," says Craig Hedberg, Ph.D., supervisor of the foodborne, vectorborne, and zoonotic diseases unit at the Minnesota Department of Health.

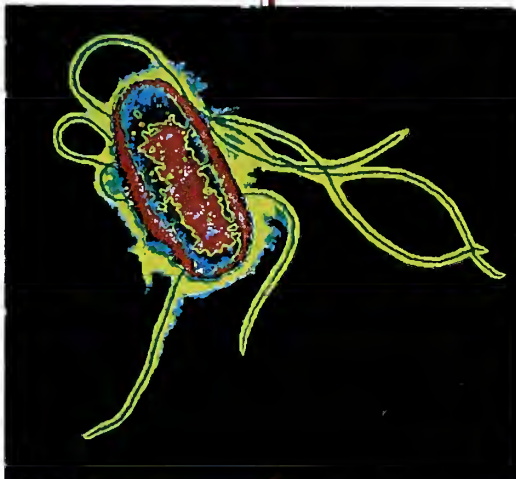
Fortunately, because of good reporting from laboratories around the state, the numbers were high enough to arouse suspicion. But slim margins are anathema to epidemiologists, who rely on numbers to tell them a story. It's up to physicians to provide those numbers. A good surveillance system begins with the physician who orders a stool culture for the patient with diarrhea.

"Physicians need to be aware of the potential for foodborne outbreaks and should realize that their patient is part of a community," Hedberg says. Not every case of diarrhea needs to be cultured, but physicians must be aware that patients with bloody diarrhea or diarrhea accompanied by fever may have illnesses that could be part of a community-wide outbreak.

Whenever there's a strong clinical suspicion of salmonellosis, *E. coli* O157:H7 disease, or campylobacteriosis, the patient needs to be cultured and public health officials notified, Hedberg says.

Many physicians won't order a culture when a patient presents with diarrhea and fever because they may not see the benefit to the patient. That's reasonable at an individual level, but obtaining a culture may help to identify whether something is occurring in the community. "There are community benefits that extend beyond the individual patient," Hedberg emphasizes.

-MKF



E. coli

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Minnesota's health department lab is slated for substantial improvements, thanks to legislation passed in the 1998 legislative session. The Food Safety Leadership Initiative received \$2.5 million to improve food safety in Minnesota. "What we're proposing is nothing less than a complete redesign and reconfiguration of our state's food safety system," Gov. Arne Carlson said earlier this year, adding that the initiative will put Minnesota in the forefront of national efforts to prevent food-related illness.

Minnesota a National Leader

Minnesota's health department already leads the pack. It has a well-established track record in detecting emerging infections and new problems of public health, dating back to its work in the late '70s when it discovered the link between tampons and toxic shock syndrome.

In 1995 the CDC recognized Minnesota's reputation for medical detection when

it selected the state as one of five sites (subsequently expanded to eight) to partake in a nationwide effort to identify and control emerging infectious diseases. "The Minnesota Department of Health has an international reputation for excellence in dealing with infectious disease problems," the CDC said when announcing the state would use new laboratory techniques to better detect outbreaks of foodborne and waterborne illnesses caused by *Salmonella*, *Shigella*, *Campylobacter*, and *Escherichia coli* O157:H7.

One of those techniques is DNA fingerprinting, a molecular subtyping that allows for more sensitive surveillance of microorganisms. The Minnesota Department of Health laboratory was the first to use the technique on a wide scale. "We have the largest surveillance among public health labs in the nation," Besser claims, noting that every isolate that comes into the lab is fingerprinted.

But Minnesota's reputation wasn't built on mere technological sophistication. By all accounts, a collaborative spirit exists between the state's laboratorians and epidemiologists that is uncommon in the world of public health.

Thomas Hennessy, M.D., an epidemiologist with the CDC who worked on assignment with the health department from 1994 to 1996, recalls the way MDH lab workers and epidemiologists were always travel-

REPORTABLE DISEASES

Since April 1995, the Minnesota Department of Health has been participating in a Centers for Disease Control and Prevention project involving hospital- and laboratory-based surveillance of several conditions. Laboratories are required to submit isolates to the health department for a number of pathogens causing invasive bacterial diseases and foodborne illnesses.

The list below shows diseases reportable to the Minnesota Department of Health. Isolates must be submitted to the health department for those in aqua.

Amebiasis (<i>Entamoeba histolytica</i>)	Hemolytic uremic syndrome	Q Fever (<i>Coxiella burnetii</i>)
Anthrax (<i>Bacillus anthracis</i>)*	Hepatitis (all primary viral types including A, B, C, D, and E)	Rabies (animal and human cases and suspects)*
Babesiosis (<i>Babesia</i> species)	Histoplasmosis (<i>Histoplasma capsulatum</i>)	Retrovirus infections (other than HIV)
Blastomycosis (<i>Blastomyces dermatitidis</i>)	Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS)†	Reye syndrome
Botulism (<i>Clostridium botulinum</i>)*	Influenza (unusual case incidence or laboratory-confirmed cases)	Rheumatic fever (cases meeting the Jones criteria only)
Brucellosis (<i>Brucella</i> species)	Kawasaki disease	Rubella and congenital rubella syndrome
Campylobacteriosis (<i>Campylobacter</i> species)§	Legionellosis (<i>Legionella</i> species)	Rocky Mountain spotted fever (<i>Rickettsia</i> species, including <i>R. canada</i>)
Cat scratch disease (infection caused by <i>Bartonella</i> species)	Leprosy (<i>Mycobacterium leprae</i>)	Salmonellosis, including typhoid (<i>Salmonella</i> species)§
Chancroid (<i>Haemophilus ducreyi</i>)*†	Leptospirosis (<i>Leptospira interrogans</i>)	Shigellosis (<i>Shigella</i> species)§
<i>Chlamydia trachomatis</i> infection†	Listeriosis (<i>Listeria monocytogenes</i>)‡	Streptococcal disease (all invasive disease caused by groups A and B streptococci and <i>S. pneumoniae</i>)§
Cholera (<i>Vibrio cholerae</i>)*§	Lyme disease (<i>Borrelia burgdorferi</i>)	Syphilis (<i>Treponema pallidum</i>)*†
Cryptosporidiosis (<i>Cryptosporidium parvum</i>)	Malaria (<i>Plasmodium</i> species)	Tetanus (<i>Clostridium tetani</i>)
Dengue virus infection	Measles (Rubeola)*	Toxic shock syndrome§
Diphtheria (<i>Corynebacterium diphtheriae</i>)§	Meningitis (caused by <i>Haemophilus influenzae</i> , <i>Neisseria meningitidis</i> , [§] or <i>Streptococcus pneumoniae</i> [§] viral agents)	Toxoplasmosis
<i>Diphyllobothrium latum</i> infection	Meningococemia (<i>Neisseria meningitidis</i>)‡	Trichinosis (<i>Trichinella spiralis</i>)
Ehrlichiosis (<i>Ehrlichia</i> species)	Mumps*	Tuberculosis (<i>Mycobacterium tuberculosis</i> and <i>Mycobacterium bovis</i>)§
Encephalitis (caused by viral agents)	Pertussis (<i>Bordetella pertussis</i>)*‡	Tularemia (<i>Francisella tularensis</i>)
Enteric <i>Escherichia coli</i> infections (<i>E. coli</i> O157:H7, other enterohemorrhagic <i>E. coli</i> , enteropathogenic <i>E. coli</i> , enteroinvasive <i>E. coli</i>)§	Plague (<i>Yersinia pestis</i>)	Typhus (<i>Rickettsia</i> species)
Giardiasis (<i>Giardia lamblia</i>)	Poliomyelitis*	Yellow fever
Gonorrhea (<i>Neisseria gonorrhoeae</i>)*†	Psittacosis (<i>Chlamydia psittaci</i>)	Yersiniosis (<i>Yersinia</i> species)‡
<i>Haemophilus influenzae</i> disease (all invasive disease)§		
Hantavirus infection		

*Report immediately by telephone, 612/623-5414

†Report on separate Sexually Transmitted Disease Report Card

‡Report on separate HIV Report Card

§Submit isolates to the Minnesota Department of Health

ing back and forth, up and down the stairs, to confer with one another. The proximity of the two groups—separated by only three floors in the health department's building at 717 Delaware Street in Southeast Minneapolis—facilitates such interaction. Contrast that with Iowa, where the health department is located in Des Moines, the laboratory in Iowa City. That's a fairly common situation, says Hennessy, and it's not conducive to medical detection. When epidemiolo-

gists are solving a puzzle, they rely on the laboratory's ability to move quickly in whatever direction the investigation leads.

In between intense spurts of activity when they're on the trail of a particular pathogen, both groups remain in a ready-alert mode, always on the lookout for alarming statistical trends. "We're an activist bunch," says Besser.

OFFICIALS PROPOSE MAJOR CHANGES IN STATE'S APPROACH TO FOOD SAFETY

Minnesota health and agriculture officials have proposed a sweeping revision of state rules for protecting food safety, based partly on a model food code developed three years ago by the U.S. Food and Drug Administration (FDA). Among the many changes, regulators and inspectors will act as consultants and educators on safe food-handling practices, and retail food managers will be required to demonstrate a command of current scientific knowledge about food safety as it applies to their own establishments.

The proposed new Minnesota Food Code will affect essentially every type of facility or operation that serves food: restaurants, grocery and convenience stores, food markets, catering operations, satellite food operations, food carts, food stands, mobile and seasonal food operations, school lunch rooms and other institutional food operations, retail bakeries, and even vending machines.

Changes in American dietary habits are creating new foodborne disease risks as people eat out more and include more fresh fruits and vegetables in their diets, says Minnesota Agriculture Commissioner Gene Hugoson. A particular concern has been the "globalization" of our food supply, as more of our foods are imported from nations with sanitation standards and practices that differ from those in the United States.

Many provisions of the code deal with very specific activities and practices, including guidelines for cooking food thoroughly or storing foods under refrigeration. For example, the code requires that ground meats be heated to an internal temperature of at least 155 degrees, for at least 15 seconds, to prevent potential health hazards like *E. coli* infection.

A special area of emphasis is health and hygiene for food service workers. The code includes require-

ments for restricting the work activities of ill workers, handling ready-to-eat foods, cleaning and sanitizing utensils, maintaining equipment and facilities, and washing hands.

Other provisions deal with issues like how long it's safe to hold prepared foods before serving them, appropriate use of food additives, use of expiration dates on ready-to-eat prepared foods, preparation of game animals and exotic species, and how to ensure the safety of wild mushrooms. The code also covers concerns like ensuring the honest presentation of foods to customers, ensuring the safety of shellfish, and ensuring the appropriate application of new technologies for processing and storing eggs.

"Under the new code, regulators will be concentrating on those activities and practices that have been scientifically demonstrated to have the greatest impact on disease risk," says Minnesota Health Commissioner Anne Barry. "Our strategies for protecting food safety will be tailored more specifically to address conditions within each individual operation or establishment, and food service managers will be asked to assume a greater role in safeguarding the quality of our food."

The new Minnesota code was developed jointly by the Minnesota Department of Agriculture, the Minnesota Department of Health, and local health agencies with responsibility for regulating food-related businesses in the state. Representatives of industry and the academic community were also involved.

The full text of the proposed new rules was published in the March 23 *Minnesota State Register*. The new rules are expected to take effect around June 15.

For more information, contact Jeanne Eggleston, MDH, 612/215-0735; fax: 612/215-0979; or e-mail: jeanne.eggleston@health.state.mn.us.

1994: Health Department Detects Nationwide Salmonellosis Outbreak

Their activism pays off, as it did during a nationwide outbreak of *Salmonella enteritidis* infections in the fall of 1994. Through a combination of vigilance, teamwork, and some bold leadership, the department not only discovered the outbreak, but also conducted an investigation that quickly led to its source—Schwan's ice cream, manufactured in Marshall, Minnesota, and distributed in 48 states.

Minnesota health department epidemiologists may have detected the nationwide outbreak, but they prefer to share the credit with the network of laboratories in Minnesota that conducted cultures when patients presented with diarrheal illnesses. Without their work, the outbreak might not have been discovered.

The Schwan's case illustrates the power of surveillance and epidemiological methods. It began in late September 1994 when the microbiology lab detected an increase in the number of *Salmonella enteritidis* cases. It takes an alert surveillance team to recognize a blip in the numbers, since in any given year, Minnesota sees 600 to 1,000 cases of salmonellosis, 10 percent to 20 percent of which are caused by *Salmonella enteritidis*.

But an upsurge was detected and the questions began. "We start with the idea that an outbreak is going on. So we begin to look for a common source," says Craig Hedberg, Ph.D., an epidemiologist who supervises the health department's foodborne, vectorborne, and zoonotic diseases unit. From there, epidemiologists look at who is getting sick and where they live.

When a cluster of cases was detected in southeastern Minnesota, the team wondered whether the outbreak may have begun at a large gathering—a wedding, perhaps, or a church supper or festival. But when that trail turned cold, the team moved on to a case control approach, at which point everything fell quickly into place.

On Wednesday, October 5, epidemiologists began interviewing persons who became ill, as well as a

control group. They asked for a day-by-day, meal-by-meal, item-by-item account of everything consumed during the five days prior to the onset of illness. They asked about brand names, restaurants, and grocery stores. Had anyone eaten lettuce, tomatoes, hamburger, chicken? Very quickly, the answer jumped right out, recalls Hedberg. "For a very high proportion of cases,

when asked, 'Did you eat any ice cream?' they said, 'Schwan's.'"

By Thursday evening, October 6, before a single carton of ice cream had been tested, the health department was ready to publicly announce Schwan's ice cream as the source of the outbreak. The announcement was made at a news conference on October 7, just two weeks after the first red flag had been raised.

Hennessy, the CDC epidemiologist who was on assignment in Minnesota at the time, recalls the risk involved in going public before microbiologic results confirmed contamination of the ice cream (the bacteria wasn't isolated from the product until October 19). Announcing the outbreak was a calculated risk

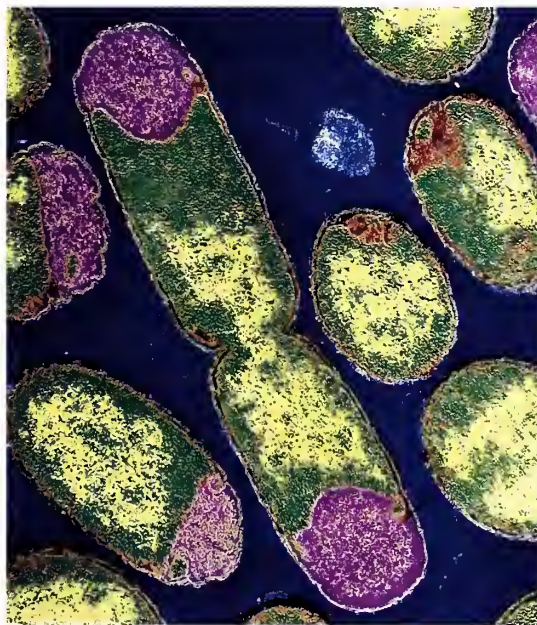
that took an act of courage on Osterholm's part, Hennessy says. After all, Schwan's was a vital part of the state's economy, but even if it hadn't been, the announcement could have unnecessarily alarmed the public.

But Osterholm and his staff were convinced of the power of their statistical methods. "The real pressing concern was that there was ice cream in Minnesota freezers that was going to be eaten that evening for dessert," Hennessy says. "[Osterholm] didn't want to let another day go by."

Had the announcement been delayed, thousands more people would have become ill. As it was, an estimated 224,000 persons became ill, making it the largest common-source outbreak of salmonellosis ever recognized in the United States. In terms of sheer numbers, this was an important outbreak, even if it wasn't the most serious. (No deaths were linked to the outbreak.)

Disease Surveillance Pays Off

The Schwan's case illustrates the practical and positive effects of disease surveillance. For example, the investigation exposed transportation as a culprit in foodborne



E. coli

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illness when it was discovered that pasteurized ice cream pre-mix had been shipped to the Schwan's plant in tanker trucks that had previously carried contaminated raw eggs. "That really increased everybody's awareness of some of the potential weaknesses in our ability to safely move foods around," Hedberg says. (Schwan's subsequently instituted a repasteurization program.)

The case also confirmed the power of epidemiological methods. It was the first outbreak in which regulatory agencies (the FDA and Minnesota Department of Agriculture) agreed to proceed based on epidemiologic data alone. The Schwan's case turned the tide, says Hennessy, making it possible to withdraw products in the absence of laboratory confirmation.

Finally, the case illustrates how even low levels of contamination can cause widespread outbreaks of illness. Episodes of food poisoning are no longer confined to the 50 folks who ate tainted potato salad at the company picnic. Because of our modern food distribution system, outbreaks can happen on the magnitude of 50,000 people or more, which is why surveillance is so important. And there are still tremendous gaps in our surveillance of foodborne diseases, Hedberg says. "Even though we've been reasonably successful in a lot of our efforts, we recognize that we're still scratching the surface." **MM**

Miriam Karmel Feldman, a Minneapolis free-lance writer, is a frequent contributor to Minnesota Medicine.

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PRACTICE RESOURCES
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Antimicrobial Resistance

Guidelines for the Primary Care Physician

David N. Williams, M.B., Ch.B., F.R.C.P.

ABSTRACT

Antimicrobial resistance is an important issue when treating patients with various bacterial, fungal, protozoal, and viral infections. Until recently, the focus of concern was on nosocomially acquired infections. However, organisms causing common community-acquired infections have now developed antimicrobial resistance. This paper provides a brief overview of this emerging global threat and discusses resistance in gram-positive organisms, outpatient oral antibiotic use, and strategies to reduce antibiotic overuse. Curbing the overuse of antibiotics is crucial to reversing the increase in drug-resistant bacteria. We need to develop guidelines and educate physicians and the public on the use of antibiotics for respiratory syndromes with predominantly viral etiologies.

Concern regarding antimicrobial resistance among bacterial, fungal, protozoal, and viral microorganisms has increased dramatically over the past decade. Ironically, antimicrobial resistance has arisen in an era of slowed antibiotic development. Increased antimicrobial resistance has profound clinical and economic consequences and needs to be confronted by society at large.^{1,2} The morbidity and mortality that results from infection with resistant microorganisms is difficult to measure, but the Centers for Disease Control and Prevention (CDC) estimates that the economic consequences are over \$4 billion annually. Historically, nosocomially acquired infections have been the primary concern, particularly in the intensive care unit, but recently, organisms causing common community-acquired infections have developed resistance. The emergence of drug-resistant *Streptococcus pneumoniae* has increased societal awareness of the problem and has renewed concerns on how best to prescribe anti-infectives, particularly in the outpatient setting.

This paper gives a brief general overview of the subject; focuses in more detail on the emerging concerns regarding drug-resistant *Streptococcus pneumoniae*, methicillin-resistant *Staphylococcus aureus* (MRSA), and strains of *Staphylococcus aureus* intermediately resistant to vancomycin (VISA); provides U.S. data on outpatient oral antibiotic use; and offers strategies to reduce antibiotic overuse.

GENERAL OVERVIEW

Microorganisms that have developed antimicrobial resistance in various settings (hospitals, nursing homes, and the community) pose an emerging global threat. For the first time in

the postantibiotic era, physicians are faced with bacterial and other previously treatable infectious agents that are resistant to all available antimicrobials. Recent examples include patients in intensive care units infected with vancomycin-resistant enterococci (VRE) and outbreaks of multidrug resistant tuberculosis.^{3,4} Reports of patients infected with strains of *Staphylococcus aureus* resistant to methicillin and intermediate in resistance to vancomycin have increased the level of concern regarding antibiotic resistance.^{5,6} The list of microorganisms with drug resistance is long and likely to increase (see Table 1).

Similarly, factors contributing to the emergence of resistance are many and complex (see Table 2). Potential approaches to contain this burgeoning problem require cooperation between multiple disciplines and authorities (see Table 3). In approaching antimicrobial resistance, the slogan, "Think globally, act locally," has relevance for us all.

DRUG-RESISTANT

STREPTOCOCCUS PNEUMONIAE

Although the focus of drug resistance in isolates of *Streptococcus pneumoniae* has been on penicillin, the term drug-resistant *Streptococcus pneumoniae* (DRSP) is preferred because of the emergence of multidrug resistance. The primary mechanism of resistance is chromosomally mediated and causes changes in the penicillin-binding proteins in the organism's cell membrane, resulting in a reduced affinity for beta-lactam antibiotics. Factors contributing to the emergence of resistance include transformation of DNA (possibly from *Streptococcus viridans*) into genes encoding penicillin-binding proteins and selective pressure as a result of

Table 1

Microorganisms demonstrating increased antimicrobial resistance (selected examples)

Microorganism	Comment
<i>Streptococcus pneumoniae</i>	Drug resistance—penicillins, macrolides, sulfa trimethoprim
<i>Streptococcus pyogenes</i>	Macrolide resistance (good example of selective pressure)
<i>Staphylococcus aureus</i>	Methicillin resistance; recent concern about vancomycin insensitivity
<i>Enterococcus faecium</i>	Vancomycin resistance (may be resistant to all currently available drugs)
Gram-negative aerobes	Multiple mechanisms, e.g., Enterobacteriaceae with extended-spectrum beta lactamases
<i>Neisseria gonorrhoeae</i>	Quinalone resistance (increasingly resistant to many antibiotics)
<i>Mycobacterium tuberculosis</i>	Multidrug resistance. Tuberculosis has increased in the HIV era. People with tuberculosis have not been followed properly due to a breakdown in public health monitoring procedures.
<i>Candida</i> species	<i>C. krusei</i> and <i>C. glabrata</i> increasingly resistant to fluconazole
<i>Plasmodium falciparum</i>	Chloroquine resistance worldwide; resistance to other prophylactic agents
Herpes simplex	Acyclovir resistance due to reduction or absence of thymidine kinase

increased beta-lactam usage. Specific serotypes of *Streptococcus pneumoniae* (6A, 6B, 9A, 14, 19A, 19F, 23F) have acquired resistance genes and account for over 80% of resistant isolates. Clinically, DRSP is seen at the extremes of age (<4 years and >70 years) often in those attending day-care or those who have been recently hospitalized or have received beta-lactam antibiotics. Primary prevention with pneumococcal vaccines has never been more important.

Historically, *Streptococcus pneumoniae* was reliably susceptible to penicillin with minimum inhibitory concentrations (MIC) of 0.1 µg/ml or less. Resistance has abruptly increased

in the last five or six years. Currently, organisms are classified with regard to penicillin resistance as either 1) intermediate: those with MICs of between 0.1 and 1.0 µg/ml (representing 66% to 88% of U.S.-resistant isolates); or 2) resistant: those with MICs ≥2 µg/ml. Currently, penicillin resistance in the Twin Cities area is 14% (68 of 490 cases of invasive pneumococcal disease reported during 1996 had resistant isolates by oxacillin screening).⁷ Penicillin resistance is often associated with resistance to other antibiotics, typically erythromycin, tetracyclines, and trimethoprim-sulfamethoxazole. Although ciprofloxacin and other

fluoroquinolones were considered poor choices for serious pneumococcal infections because of their marginal MICs (1-2 µg/ml), the newer fluoroquinolones (and especially trovafloxacin) work well even against penicillin-resistant strains.⁸

The appearance of DRSP has prompted changes in laboratory protocols for sensitivity testing. All clinically significant isolates (blood, cerebrospinal fluid, etc.) should be screened for penicillin resistance using the oxacillin disk diffusion test. Isolates with zone diameters of ≥20 mm around a 1 µg oxacillin disk can be considered susceptible to beta-lactam antibiotics. If an isolate has a zone diameter of 19 mm or less, use conventional methods or antimicrobial gradient strips (Etest—AB BIO-DISK, Piscataway, NJ) to determine MICs to penicillin and other clinically important drugs.

There are no firm or established guidelines for treating DRSP, and the precise role of the newer fluoroquinolones is unclear. However, it is suggested that:

- Patients with bacteremia and pneumonia due to intermediately resistant organisms (penicillin MIC 0.1-1.0 µg/ml) should be treated initially with high-dose beta lactams (specifically ceftriaxone or cefotaxime). Subsequently, therapy can be switched to an oral cephalosporin, principally cefprozil or cefpodoxime, or to clindamycin, levofloxacin, or trovafloxacin.

- Patients infected with resistant isolates (penicillin MIC ≥2 µg/ml) should be treated with vancomycin or imipenem (or meropenem) with or without rifampin.

- Patients with meningitis due to resistant organisms should be treated with ceftriaxone plus vancomycin (dose at 2 gm/day or 40 mg/kg/day) with or without rifampin.

- Patients with acute otitis media requiring antibiotic therapy present a significant clinical challenge. Currently, oral amoxicillin is the recommended first line of therapy, but failure to respond should prompt alternate treatment with cefprozil, cefpodoxime, or possibly clindamycin.

METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS*

Methicillin-resistant *Staphylococcus aureus* (MRSA) first appeared in both Europe and the United States in the 1960s. The National Nosocomial Infection Surveillance (NNIS) data indicate that MRSA prevalence increased from 2.4% in 1975 to 29% in 1991. Recently, the *Journal of the American Medical Association* reported a dramatic increase in community-acquired MRSA infections in children, although isolates were more likely to be clindamycin-sensitive than nosocomially acquired MRSA.⁹

The mechanism of resistance results from the production of a novel penicillin-binding protein (PBP) 2a that has reduced affinity for beta lactams. The production of this PBP is genetically determined as a result of acquiring the *mec A* gene. The designation MRSA denotes resistance to all beta lactams (methicillin, oxacillin, nafcillin, and the cephalosporins). MRSA strains show varying resistance to clindamycin, trimethoprim-sulfamethoxazole, and ciprofloxacin. The precise pattern of resistance varies within and between communities, but strains acquired in the community are generally more susceptible.

The risk factors for acquiring MRSA include:

- advanced age;
- male gender;
- previous hospitalization;
- increased length of hospitalization;
- ICU or burn unit stay;
- chronic disease state;
- prior and prolonged antibiotic therapy;
- exposure to colonized or infected patients;
- presence of a wound; and
- presence of invasive indwelling devices (including endotracheal tubes).

Other risk factors include the size of the hospital (increased prevalence of MRSA in hospitals with >500 beds) and a high preponderance of nursing home patients and patients with intravenous drug abuse problems.

To determine appropriate antibiotic use, we must differentiate between colonization and infection with

Table 2

Factors contributing to the emergence of antimicrobial resistance

- Selection of antibiotic resistance genes among virtually all bacterial pathogens.
- Increased use of antimicrobial agents (selective pressure).
- Increase in high-risk (immunodeficient) human populations.
- Prolonged survival of individuals with chronic disease requiring hospitalization and antibiotic therapy.
- Congregate facilities as reservoirs for multidrug resistant bacteria (hospitals, nursing homes, daycare centers, etc.).
- Lack of rapid, accurate diagnostic tests to distinguish between viral and bacterial infection, leading to excessive antibiotic use.
- Public expectations and pressure on physicians to treat minor illnesses with antibiotics.
- Lack of funds for national and regional epidemiologic surveillance of patterns of infection and resistance.
- Increased antibiotic use in animal husbandry and agriculture.
- Increased international travel and commerce.

Modified from Segal-Maurer, et al.²²

Table 3

Potential approaches to antimicrobial resistance

Strategies for detection, prevention, and control of antibiotic resistance include many disciplines and multiple approaches:

- Epidemiology (surveillance and monitoring of antimicrobial resistance patterns).
- Microbiology (rapid detection; accurate and reproducible antimicrobial susceptibility data).
- Socioeconomics
 - a) Reduce/monitor antibiotic use in veterinary medicine, animal husbandry, etc.
 - b) Control clinical use of antibiotics (optimize prophylactic and empiric treatment).
- Infection control approach (policies for isolation, cohorting, hand washing, gowns, etc.).
- Quality control—use of key performance indicators (appearance and number of resistant organisms; antibiotic use profiles, etc.).

MRSA. It is estimated that the colonization to infection rate in hospitalized patients is around 30%, compared with 5% to 15% in nursing home patients. Until recently, vancomycin was the cornerstone of treatment. However, vancomycin alone may not be the ideal treatment regimen for patients with endocarditis or

persistent bacteremia, in which case gentamicin together with rifampin (if the isolate is susceptible) should be added. As previously noted, the fluoroquinolones (and particularly the newest member, trovafloxacin) and trimethoprim-sulfamethoxazole may be effective against this organism. However, none of these drugs is

effective in eliminating colonization.

Physicians should review infection-control measures when they discover patients colonized or infected with MRSA. Infection-control measures are more effective in ending epidemics and less successful in situations where MRSA is endemic. Standard precautions (universal precautions and blood and body substance isolation) should be applied. Gloves should be used whenever possible. Hand washing is vitally important. In epidemic situations, patients should be isolated, divided into cohorts, and screened for nasal carriage. Nasal carriers can be treated with varying success with topical mupirocin with or without oral rifampin, or minocycline, or trimethoprim-sulfamethoxazole. Colonization with MRSA is not a reason to prevent the transfer of a patient to a long-term care facility. Furthermore, treatment to eliminate colonization is often futile since these patients rapidly become recolonized and reinfected. Treatment in such instances has the potential for antibiotic-associated side effects, unnecessary expense, and inconvenience to the patient and family.

STAPHYLOCOCCUS AUREUS INTERMEDIATELY RESISTANT TO VANCOMYCIN

In 1996 and 1997 reports came of patients infected with multiresistant strains of *Staphylococcus aureus* intermediately resistant to vancomycin (VISA).^{5,6} The exact mechanism of resistance is unclear. The first isolate was reported in Japan, and more recently, cases have been reported in the United States (Michigan and New Jersey). These organisms have MICs to vancomycin of approximately 8 µg/ml and fortunately have been treatable with combinations of existing drugs. All of these patients underwent prior treatment with vancomycin. Although in vitro resistance to vancomycin had previously been reported, the specter of clinically significant isolates of methicillin-resistant and vancomycin-resistant *Staphylococcus aureus* is alarming and has prompted the development of provisional guidelines to address the issue.¹⁰

OUTPATIENT ORAL ANTIBIOTIC USE

Surveys of primary care physicians' oral antibiotic prescribing patterns in the 1980s and 1990s have drawn attention to the increased use of more expensive broad-spectrum antimicrobial agents, such as cephalosporins and amoxicillin-clavulanic acid, and the reduced use of less expensive narrow-spectrum drugs, such as the penicillins.¹¹ Data from the United States indicate that although the number of antimicrobial drugs prescribed increased between 1980 and 1992, antibiotics represented a fairly constant 12% to 14% of all drugs prescribed.¹¹ In 1992 approximately 110 million courses of antibiotics were prescribed, primarily for various respiratory syndromes. The precise clinical indication for antibiotic therapy varies with age, with otitis media predominating in children and sinusitis in adults.

One of the more concerning aspects of antibiotic use in the United States is for infections with predominantly viral etiologies, such as colds, various upper respiratory syndromes, and acute bronchitis.¹² Similar patterns of antibiotic prescribing have appeared elsewhere in the world.

STRATEGIES TO REDUCE ANTIBIOTIC OVERUSE

Curbing the overuse of antibiotics is crucial to reversing the alarming increase in drug-resistant strains of pathogenic bacteria. The *Journal of the American Medical Association* recently published a discussion on the importance of appropriate dosing of antibiotics and on the optimal duration of antibiotic therapy.¹³ Controversy exists over the appropriate length of antibiotic therapy for many common infectious diseases. Data indicate that short-course (three-day) therapy for uncomplicated urinary tract infections is as effective as more prolonged therapy, but data on abbreviated anti-infective therapy for other common infections are lacking. Short courses of anti-infective therapy are attractive because of the potential to reduce selective pressure on microorganisms as well as reduce costs and the likelihood of drug-

associated side effects.

Although in some countries over-the-counter antibiotic use is an important factor in drug resistance, excessive in-hospital prophylactic and ambulatory antibiotic use are the main culprits in the United States. In the ambulatory setting, both physician and patient factors lead to antibiotic overuse. The physician factors include:

- difficulty making a specific diagnosis (e.g., distinguishing viral from bacterial infection);
- lack of knowledge of the natural history of a specific disease process (e.g., a persistent cough commonly occurs in many viral respiratory infections);
- malpractice concerns;
- insufficient time to discuss why an antibiotic is not needed; and
- misconceived notions of patient expectations.

Patients also play a role in antibiotic overuse. Patient factors include:

- unrealistic expectations of the disease process (especially duration of symptoms);
- lack of education about the need to avoid self-treatment with leftover antibiotics and to complete the prescribed course of therapy;
- lack of knowledge of antibiotic side effects and long-term consequences, including resistance; and
- the expectation that a prescription is an optimal outcome, as opposed to an improved understanding of a disease.

PHYSICIAN APPROACHES TO REDUCING OVERUSE

Many approaches can be used to reduce the overuse of antibiotics.

• **Physician guidelines:** In response to an increase in erythromycin resistance among Gp A Streptococci in Finland, nationwide recommendations were issued calling for a reduction in the use of macrolide antibiotics for respiratory and skin infections. This policy resulted in both a reduction in use of macrolides and a decline in the frequency of erythromycin-resistant Gp A Streptococci.¹⁴

• **Physician and patient education:** Journals and lectures for physicians and TV and radio programs and newspaper articles for patients

can be used to educate people on the hazards of antibiotic overuse and the emergence of resistant organisms. For example, the public could be educated on the Icelandic experience with penicillin-resistant pneumococci;¹⁵ reduced antibiotic use resulted in a reduction in the number of isolates of penicillin-resistant *Streptococcus pneumoniae*.

• **Physician aides:** Computer-assisted programs, for example, could help inform physicians (see recent experience on in-hospital use¹⁶).

DISEASE-SPECIFIC APPROACHES

1) **Otitis media:** Pioneering work in the Netherlands¹⁷ calls for withholding antibiotics for unclear indications and deferring initiation of antibiotics for several days while monitoring clinical progress.

2) **Acute sinusitis:** Recent research questions the routine use of antibiotics in acute maxillary sinusitis.¹⁸ Other research suggests limiting the duration of the antibiotic therapy to three days.¹⁹

3) **Acute bronchitis:** Emphasize viral etiologies and withhold antibiotics in otherwise healthy adults.²⁰

4) **Acute uncomplicated urinary tract infection:** There is now a consensus that three days of sulfa-trimethoprim or a quinolone for acute uncomplicated urinary tract infections in women (16 to 65 years) is appropriate.²¹

CONCLUSION

Antimicrobial resistance is now an everyday reality. Although the root causes of antimicrobial resistance are many, selective pressure as a result of overuse of antimicrobial agents is an important factor. Antimicrobial resistance has been reported for many microbial organisms but the recent increases in drug-resistant isolates of *Streptococcus pneumoniae*, *Enterococcus* species, *Staphylococcus aureus*, and *Mycobacterium tuberculosis* have caused concern among the medical profession and society at large. Strategies to curb emergence of resistance require cooperation among many disciplines and authorities. However, experiences from other countries have demonstrated that an increase in public and professional

awareness of the adverse consequences of antimicrobial overuse for respiratory syndromes with predominantly viral etiologies can result both in more appropriate antimicrobial use and improved patient care. To effect such changes will require increased public awareness and understanding of the role of antimicrobials and physician willingness to implement antimicrobial guidelines for defined situations.

MM

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An Epidemiologic Summary of the AIDS/HIV Epidemic in Minnesota

Richard Danila, Ph.D., M.P.H.

ABSTRACT

A cumulative total of 3,202 AIDS cases and 2,355 non-AIDS cases of HIV infection have been diagnosed in Minnesota and reported to the Minnesota Department of Health since 1982. The number of AIDS cases and HIV infection cases diagnosed annually peaked five to 10 years ago. New treatments for HIV infection have led to a marked reduction in mortality. The number of deaths due to AIDS/HIV in 1997 (76) was the lowest number in Minnesota since 1986.

Several trends continue to evolve in reported AIDS/HIV cases. First, the proportion of female cases has increased over time. Second, male-to-male sex remains the most common exposure category, but the proportion has declined over time. In contrast, the proportion of cases related to injecting drug use and heterosexual contact has increased over time. Third, an increasing proportion of AIDS/HIV patients are black. Although progress has been made in reducing AIDS/HIV incidence, more Minnesotans are living with AIDS/HIV than ever before.

Nearly 17 years after the first description of AIDS, the AIDS/HIV epidemic continues unabated throughout the world. The World Health Organization estimates that 16,000 people are infected every day in the world, with 31 million people now living with AIDS/HIV.¹ In the United States more than 600,000 AIDS cases have been reported to date.² The prevalence of AIDS/HIV is estimated to be between 650,000 and 900,000 people.³ In Minnesota, more than 5,500 people have been diagnosed with AIDS/HIV.

The Minnesota Department of Health (MDH) Acute Disease Epidemiology Section is responsible for determining the epidemiology of AIDS/HIV infection in Minnesota. A variety of data sources are used to determine the distribution, spread, and impact of AIDS/HIV in the state. MDH has collected information on AIDS cases since Minnesota's first case was diagnosed in 1982.

AIDS surveillance data are useful because they are complete and accurate; most AIDS cases are reported to MDH within six months of diagnosis. Monitoring trends in AIDS cases helps determine groups at risk for HIV infection; in turn, these groups can be targeted for prevention and service resources. However, AIDS data also have limitations because they represent people infected with HIV years ago. Recent improvements in therapy have allowed HIV-infected persons to live longer without developing AIDS-defining conditions; thus, AIDS data for more recent time periods are difficult to interpret and are less useful.

In October 1985, MDH was the first health department in the United States to mandate reporting of HIV infection in the absence of AIDS. The advantage of HIV surveillance data

over AIDS data is that HIV cases generally represent more recent infections than AIDS cases. Trends in HIV surveillance data can be examined to determine emerging groups at risk for HIV infection and future trends in AIDS cases.

THE NUMBER OF MINNESOTA CASES

As of January 1, 1998, a cumulative total of 3,202 AIDS cases had been diagnosed and reported to MDH. The number of AIDS cases diagnosed each year increased steadily from 1982 to a peak of 423 cases in 1992 (see Figure 1). The 1992 peak is likely attributable in part to the 1993 change in the AIDS surveillance case definition allowing for retrospective diagnoses. Since then the number of AIDS cases diagnosed annually has declined consistently, with 181 cases diagnosed in 1997. This decline represents both a reduced incidence of HIV and the effect of improved therapy.

A cumulative total of 2,355 non-AIDS cases of HIV infection had been reported as of January 1, 1998. The number of HIV infections diagnosed annually peaked in 1987 (406 cases) and has declined since then (see Figure 1). This decrease in both AIDS and HIV cases suggests that Minnesota's epidemic may be declining since the surveillance methodology did not change during this time.

New treatments for HIV infection have led to a marked reduction in mortality. Deaths due to AIDS have significantly declined over time (see Figure 1). The number of deaths due to AIDS/HIV in 1997 (76) was the lowest number in Minnesota since 1986. Although this is good news, the reality is that more people are living with AIDS/HIV than ever before (see Figure 2). As of January 1,

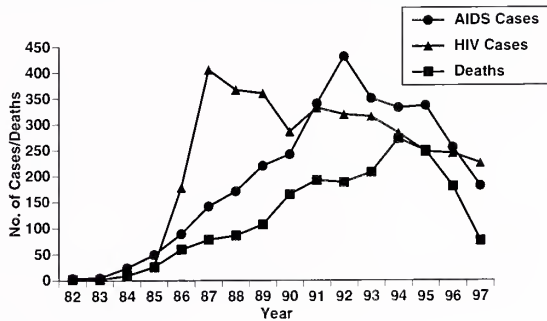
AIDS/HIV Cases by Year of Diagnosis, and Deaths by Year of Death, Minnesota, 1982-1997

Figure 1

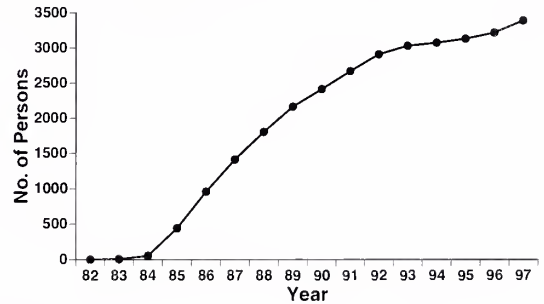
Persons Living with AIDS/HIV at Year End, Minnesota

Figure 2

Table 1

*Minnesota adult/adolescent AIDS cases by exposure category over time, January 1, 1998**

Exposure category	1/82-12/90		1/91-12/93		1/94-12/95		1/96-12/97	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	764	(81)	790	(71)	433	(65)	253	(60)
Injecting drug use (IDU)	36	(4)	96	(9)	66	(10)	46	(11)
Men who have sex with men & IDU	55	(6)	83	(8)	50	(7)	25	(6)
Hemophilia/coagulation disorder	33	(3)	27	(2)	9	(1)	3	(<1)
Heterosexual contact	24	(2)	46	(4)	57	(9)	38	(9)
Transfusion, blood/components	16	(2)	15	(1)	4	(1)	0	(0)
Other/undetermined	17	(2)	50	(5)	49	(7)	58	(14)
Totals	945	(100)	1107	(100)	668	(100)	423	(100)

*The table excludes inmates of federal and private correctional facilities.

1998, approximately 3,500 people were known to be living with AIDS/HIV infection in Minnesota. Their care requires significant resources and services. In addition, this is a pool of infected people who may continue to transmit HIV.

TRENDS IN AIDS/HIV CASES

AIDS SURVEILLANCE DATA

Several trends continue to evolve in reported AIDS cases. First, the proportion of female AIDS patients has

increased over time, from 4% of all cases in the first nine years of the epidemic to 16% of all AIDS cases diagnosed in 1996-97. Second, male-to-male sex remains the most common exposure category, but the proportion of these cases has declined over time (see Table 1). In contrast, the proportion of cases related to injecting drug use and heterosexual contact has increased over time. From 1982 to 1990, 4% of the cases were related to injecting drug use and 2% to heterosexual contact; in 1996-97

these proportions increased to 11% and 9%, respectively. Third, the proportion of AIDS cases among black Minnesotans is increasing while cases identified among white Minnesotans are decreasing (see Table 2). In 1996-97, 63% of AIDS patients were white, compared with 85% diagnosed before 1991. Similarly, 27% of AIDS patients diagnosed in 1996-97 were black, compared with 10% diagnosed before 1991. This imbalance is particularly striking considering that less than 3% of Minnesota's population is black.

Table 2

*Minnesota AIDS cases by race/ethnicity over time, January 1, 1998**

Race/ethnicity	1/82-12/90		1/91-12/93		1/94-12/95		1/96-12/97	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
White	810	(85)	884	(79)	471	(70)	268	(63)
Black	100	(10)	156	(14)	143	(21)	117	(27)
Hispanic	31	(3)	52	(5)	37	(6)	21	(5)
Asian	4	(<1)	3	(<1)	2	(<1)	7	(2)
American Indian	8	(1)	20	(2)	18	(3)	12	(3)
Totals	953	(100)	1115	(100)	671	(100)	425	(100)

*The table excludes inmates of federal and private correctional facilities.

HIV VS. AIDS SURVEILLANCE DATA

These trends are even more pronounced when comparing HIV infection (non-AIDS) case data with AIDS case data. For example, the overall proportion of female AIDS cases is 9%, compared with 17% of HIV infection cases. Male-to-male sex accounts for 71% of all AIDS cases, compared with 62% of HIV infection cases. Similarly, injecting drug use accounts for 8% of all AIDS cases and 12% of HIV infection cases, while heterosexual contact is associated with 5% of AIDS cases and 11% of HIV infection cases. Seventy-seven percent of AIDS patients are white, compared with 65% of HIV patients. Sixteen percent of AIDS patients are black, compared with 27% of HIV patients.

CHILDHOOD INFECTION

Forty-seven children have been diagnosed with AIDS/HIV infection (21 AIDS/26 HIV infection) to date. The majority (36) of these were born to HIV-infected women and acquired their infection perinatally. Through blinded unlinked seroprevalence surveys of childbearing women, MDH estimated that three to seven Minnesota infants were born HIV-infected each year from 1991 to 1995. With

the identification of HIV infection in pregnant women and the increased use of antiretroviral therapy during pregnancy, the number of infected infants born each year since 1995 is likely to have decreased.

CONCLUSION

The Minnesota AIDS/HIV epidemic is constantly changing as it affects new population groups. Although the incidence of AIDS/HIV in Minnesota has fallen, several hundred new infections occur annually. In addition, because of increased survival, a growing number of Minnesotans are HIV-infected. Monitoring the epidemic continues to be critically important for setting priorities in public and private prevention efforts and for helping to direct allocation of services, including case management and other social services, health insurance, and housing.

MM

Richard Danila is supervisor of the HIV and Emerging Infections Unit, Acute Disease Epidemiology Section, Minnesota Department of Health.

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vention. HIV/AIDS surveillance report, 1997; Atlanta: Centers for Disease Control and Prevention, 1997.

3. Karon JM, Rosenberg PS, McQuillan G, Khare M, Gwinn M, Petersen LR. Prevalence of HIV infection in the United States, 1984 to 1992. JAMA 1996;276:126-31.

ANNOUNCEMENTS

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PROCESSING DIFFICULTIES CAUSE DELAYS AT AMA

Difficulties at the American Medical Association have caused delays in processing *some* memberships for Minnesota AMA members. The MMA has processed all AMA dues it has received and has forwarded these dues to the AMA; however, the AMA has not credited some dues toward memberships. Minnesota AMA members who believe they have been billed for previously paid memberships, or who are not receiving *JAMA* or *AMNews*, should call the MMA's dues processing staff at 612/378-1875 or 800/DIAL MMA (342-5662).

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MMA OFFICER NOMINATIONS SOUGHT

The Minnesota Medical Association Nominating Committee is beginning the process of nominating candidates for the MMA offices of president-elect, vice president, secretary, treasurer, speaker of the MMA House of Delegates, and vice-speaker of the House of Delegates. If you are interested in running for election, or if you would like to nominate another MMA member, please contact your representative on the nominating committee. Elections will be held at the 1998 MMA Annual Meeting in St. Paul October 7-9.

The members of the nominating committee are: Raymond G. Christensen, M.D., chair; Robert C. Moravec, M.D. (East Metro); Nicholas Bernier, M.D. (North Central); Paul Sanford, M.D. (Northeast); Knute Thorsgard, M.D. (Northwest); Michael J. Murray, M.D. (Southeast); Elton Wing, M.D. (Southwest); and Benjamin H. Whitten, M.D. (West Metro).

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Unveils Center for Physician Advocacy

The MMA proudly announces creation of the new Center for Physician Advocacy, part of a major restructuring designed to highlight all that the MMA does and will continue to do on behalf of Minnesota physicians and patients.

The MMA has long been a dedicated and powerful force working for physicians in:

- state and federal legislation,
- health law,
- ethics,
- health care delivery systems,
- health economics,
- public health, and
- quality and data.

The Center for Physician Advocacy will make MMA efforts in each of these arenas "more focused" in an effort to better serve physician members and their patients, said Patricia Franklin, MMA director of health law.

The MMA's Center for Physician Advocacy encompasses three departments: the department of state and federal legislation, with David Renner as director; the department of health law, with Patricia Franklin as director; and the department of health economics and policy analysis, with Janet Silversmith as director.

Some of the Center's first-year goals include pursuit of health plan liability legislation, creation of a Minnesota physician practice profile, and design of a physician services contract review program.

New Publication Planned

The Center's newsletter, *The Physician Advocate*, will provide in an appealing format succinct, timely

updates on legislative, legal, ethical, and managed care issues of interest to Minnesota physicians. *The Physician Advocate* will be published twice monthly during the legislative session and once a month the remainder of the year.

Telephone Hotline Established

A telephone hotline, 888/662-6774, has been set up to give physicians immediate access to the Center for Physician Advocacy.

The hotline will be one of several communications tools—along with online updates on a revamped MMA Web page, legislative Internet links, and research reports—connecting MMA members to the Center and vice versa. Members with concerns related to quality of care, access to care, physician-patient relationships, clinical decision-making, and reimbursement will be invited to call or e-mail the Center for help or advice.

A 'New Era' at the MMA

MMA CEO Paul S. Sanders, M.D., said the creation of the Center for Physician Advocacy "marks the advent of an exciting new era at the MMA.

"In developing the Center for Physician Advocacy we've had the chance to zero in more closely on some of the concerns our members and their patients are expressing today," Sanders said. "The practice of medicine is changing more rapidly than ever, and so are physicians' needs—we're confident that this is the best way for us to stay responsive to those needs."

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Viewpoint

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Paul C. Matson, M.D., Chair
MMA Board of Trustees

MMA Introduces the Center for Physician Advocacy

The MMA is introducing the Center for Physician Advocacy to make it easier for you and other members to come to the MMA for answers to your questions and help with your concerns. The Center's mission is to advocate for physicians and their patients. This, of course, is not a new role for the MMA. Your association has long been a powerful force representing physicians at the state and federal legislature, in discussions with health plans, with the Minnesota Board of Medical Practice, and other regulatory and community agencies.

But do most members realize how much the MMA does on their behalf? Or know whom to call if they have a question? The new Center for Physician Advocacy expands MMA activities, makes MMA accomplishments more visible, and encourages physicians to turn to the MMA for assistance and information.

You may call the new MMA Center for Physician Advocacy Hotline at 888/662-6774 for help or information on such issues as quality of care, access to health care, physician-patient confidentiality, patient-physician relationships, reimbursement, clinical decision-making, professionalism and the health of the community.

Although the MMA cannot offer legal assistance for individuals or negotiate on their behalf with health plans, the association will direct you to the best resource. When a number

of our members have similar complaints or difficulties, the MMA is able to act on behalf of the larger group. The 9,600 physicians in the MMA bring a power to the discussion that individuals or small groups cannot.

There are three MMA Center for Physician Advocacy departments:

- 1) State and Federal Legislation, David Renner director;
- 2) Health Law, Patricia Franklin director; and
- 3) Health Economics and Policy Analysis, Janet Silversmith director.

Most members are aware of the MMA's outstanding track record in passing important health care legislation. Thanks to MMA advocacy at the 1997 Legislature, you did not have to pay the \$400 surcharge on your medical license this year and your provider tax was reduced to 1.5 percent. The MMA played a vital role at the 1998 Legislature as well, blocking attempts to extend the malpractice statute of limitations and passing legislation to limit the use of a physician's DEA number. (See page 38).

Health law is another important MMA advocacy arena, but one that may not be as visible to our members. What doesn't happen is often as important as what does. How many members realize the key role the MMA played in helping Medical leaders understand the difficulties raised by their plan to institute utilization review for diagnostic imaging

services? The MMA also helped alert physicians to proposed changes to the Blue Cross and Blue Shield provider agreements, giving physicians an opportunity to make more informed decisions. And MMA legal staff developed the arguments necessary to prevent changes in the statute of limitations that were being proposed at the Legislature.

The MMA is also a major player in the field of health economics and policy analysis. Recently, the MMA Board of Trustees adopted a strong resolution opposing the 1997 version of the Evaluation and Management documentation guidelines. The MMA organized an E&M summit at which members suggested ways to correct the flawed guidelines, and the MMA then forwarded results to the AMA. The MMA is a founding member of the Geographic Coalition, a group of 24 states working to reduce disparities in Medicare reimbursement.

To make sure our members know how much the Center is doing on their behalf, MMA publications are being redesigned to present the news in a clearer, more attractive format. Soon you will receive the first issue of *The Physician Advocate*, a three-color monthly newsletter that will keep you up to date about activities of the Center for Physician Advocacy. This publication will replace *The Monitor in Brief*. In addition, *Minnesota Medicine* will introduce a news section to replace *The Monitor*.

Currently, MMA news and information about the association is readily available on the Internet (at www.mnmed.org). Some sensitive information is reserved for members only and you must know the password to access it. If you don't know the password, call 612/378-1875 or 800/DIAL-MMA (342-5662). This summer the MMA home page will be redesigned to reflect the recent reorganization and to make it easier for you to navigate the Web.

We believe the Center for Physician Advocacy will encourage member and non-member physicians alike to come to the MMA for help.

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Minnesota Physicians Weigh in on E&M Documentation Guidelines

The Minnesota Summit on E&M Documentation Guidelines was a "great success" yielding numerous constructive recommendations, said Janet Silversmith, MMA director of health economics and policy analysis. Nearly 100 people, including 65 MMA physicians, attended the April 14 gathering.

Among the recurring themes at the MMA summit were:

- That the guidelines should serve as *tools* for physicians, not rigid requirements;

- That the guidelines must be field-tested to determine their impact on practicing physicians—including time spent on documentation and economic costs associated with dictation/storage of information;

- That it is imperative for reviewers who examine documentation to be properly trained and to possess some understanding of the practice of medicine;

- That medical record documentation must serve first and foremost as a means of communicating pertinent information about a patient to other physicians, not as a billing tool. The current guidelines ignore this primary focus and should be modified to more evenly balance the primary purpose of documentation with the secondary needs of payers;

- That there is a troubling tendency, in attempting to comply with the guidelines, to develop a "cookie cutter" approach to documentation. Physician educators of medical students and residents expressed great concern about the potential impact of this approach on future physicians, who may come to focus on the "form" or "template" rather than valuing the words that are communicated.

At press time, Silversmith was preparing for the American Medical Association's E&M documentation guidelines "fly-in" in Chicago, where

participants were to discuss complaints and suggestions from physicians around the country. Silversmith forwarded the recommendations from Minnesota physicians to the AMA in advance of the April 27 fly-in.

The MMA summit represents a somewhat unusual approach to the struggle over the current documentation guidelines, Silversmith said. While the MMA is one of many state medical societies that has heard negative comments about the guidelines from its members, its response—creating a forum for individual physicians to prepare a detailed message about the guidelines—was unique.

"The MMA knew that the guidelines were problematic, but without specific, practical input received at the summit from practicing physicians, our message on the guidelines would have been much weaker," Silversmith said.

For more coverage of the April 14 summit and a report on the AMA fly-in, see the premier issue of *The Physician Advocate* in mid-May.

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MMA Seeks Nominees for Stop the Violence Award

♦♦♦♦♦ MMA MEMBERS ARE INVITED to submit nominations for the annual Stop the Violence Award, to be presented at the 1998 MMA Annual Meeting in St. Paul October 8. Letters soliciting nominations have been sent to legislators, women's shelters, and agencies that serve women and children affected by domestic violence.

If you would like more information about the MMA's Stop the Violence Award, call Lorrie Holmgren at the MMA at 612/378-1875 or 800/DIAL MMA (342-5662).

MMA Announces Edward Purcell Award for Young Physicians

Young physicians who have made outstanding contributions to their communities will be considered for the MMA's newest achievement award, The Edward Purcell, M.D., Award for Exemplary Service.

Any MMA member physician under age 40 who has compiled an outstanding record of community service is eligible for nomination. Examples of community service include:

- Leadership in expanding voluntary health programs,
- Leadership in promoting cultural or arts activities,
- Service as a public official,
- Assistance in making free clinical care available to the needy, or

- Coaching an athletic team.

The award may be presented to a young physician in each trustee district. In the interest of increasing member visibility, recipients will receive the award in their respective trustee districts.

Edward Purcell, M.D., was the first physician in Minnesota and served as the post-surgeon at Fort Snelling from 1819 to 1825. He died in his post serving the distressed pioneer population.

For more information, or to nominate an MMA member for the Edward Purcell Award, contact Karen Tourdot at the MMA at 612/378-1875 or 800/DIAL MMA (342-5662).

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Southern Minnesota Physicians Cooperate in Tornadoes' Aftermath

When St. Peter family physician William G. Shores, M.D., says he and his colleagues were "blown away" by the tornado that ripped through their community March 29, he's speaking figuratively.

"We've always had disaster training," Shores said—but the training sessions assumed that in a disaster, health care providers would be working with little amenities like, say, electrical power and communications capabilities. In the immediate wake of the 1.25-mile-wide twister, St. Peter physicians had neither.

"It made for an anxious few hours," Shores said. "We were just so thankful that there were no major injuries."

Shores was the St. Peter Clinic physician on call that day. The St. Peter tornado, one of at least seven that devastated several Southern Minnesota communities, left the clinic totally without power. Shores joined several other physicians—including an obstetrician who was visiting St. Peter from out of town—at the storm-damaged St. Peter Community Hospital and Health Care Center, which was operating on an auxiliary power system.

The hospital's emergency department continued—and continues—to function in the tornado's aftermath. Shores said physicians there saw 16 patients that Sunday, most with cuts and bruises.

St. Peter Hospital Damaged

But the facility was far from unscathed. Colleen Spike, administrator of the hospital, said at press time that damage estimated at \$650,000—and that figure is likely to increase as further assessment takes place. The hospital's nursing home residents were moved to the St. Peter Regional Treatment Center, where they remained until the nursing home reopened April 21.

And hospital inpatients were transferred to Immanuel-St. Joseph's in Mankato or to the Minnesota

Valley Health Center in Le Sueur; St. Peter was projected to resume providing inpatient care by April 27. Since both Mankato and Le Sueur are about 10 miles south and north of St. Peter, respectively, "it hasn't presented a big problem," Shores said.

Robert W. Christensen, M.D., an emergency medicine specialist at Immanuel-St. Joseph's, said physicians at that hospital continue to see patients with injuries sustained in cleanup and construction efforts at tornado-ravaged sites in the area.

A Social, Environmental, and Personal Disaster

Curt Stolee, M.D., a family physician who retired January 1, was one of the several physicians who pitched in at the St. Peter hospital the day of the storms. He emerged from his basement to find his neighborhood strewn with enormous trees, and houses just a block from his were "pretty well leveled." Stolee was unable to drive to the hospital, so he walked—and what normally amounts to a 10-minute stroll had become, that afternoon, a 40-minute hike.

Stolee said that although the tornado was a huge "social, environmental, and personal disaster," he found it "almost miraculous" that more people weren't severely hurt or killed.

"Well over 90 percent of people listened when they heard the sirens and went for the basement," Stolee said. "As far as people's lives and health, it could have been a lot worse."

MMA Creates Tornado Relief Fund; Individuals Can Help

The MMA has donated \$1,000 to help the St. Peter-area community recover from tornado damage and has established a special fund to allow MMA physicians to make individual contributions. The fund has been set up through the Minnesota

Physicians Foundation, the charitable arm of the MMA.

The money will be donated to St. Peter Community Hospital and Health Care Center and used by the medical staff for projects such as a community forum to help residents deal with the psychological impact of the disasters.

"There are so many tasks that must be done immediately that the full psychological impact may not hit until much later," said Kathryn Kramer, M.D., a family physician in St. Peter.

For more information about how to help in the MMA's tornado relief effort, see the ad on page 37, or go to the MMA Web page, located at www.mnmed.org • • • • •

Universal Service Fund Discounts Available

Applications are now available from the Rural Health Care Corp. (RHCC) for Universal Service Fund discounts, intended to help rural health care providers, schools, and libraries offset the cost of initiating telecommunications services.

The RHCC is a nonprofit entity established by the Federal Communications Commission (FCC) to administer the rural health care discount program. The FCC adopted a Universal Service Order in 1997 that created a \$400 million annual fund to provide support to rural health care providers for authorized telecommunications services.

Discounts are available on a first-come, first-served basis. Application forms and instructions for completing them can be obtained by calling the Rural Health Care Corp. at 800/229-5476. Applications can also be downloaded on the RHCC Website at www.rhccfund.org

More information also is available on the following Websites: www.fcc.gov/healthnet and www.neca.org/funds • • • • •

MMA Tornado Relief Fund

Help St. Peter Community Cope with Tornado's Aftermath

The Minnesota Medical Association has donated \$1,000 to help the St. Peter community recover from damage caused by tornadoes that swept across southern Minnesota in March. The MMA has also set up a special fund to allow MMA physicians to make individual contributions.

“After a disaster occurs, there are so many tasks that must be done immediately, that the full psychological impact may not hit until much later. We want to help people deal with the aftermath of the tornado.”

—Kathryn Kramer, M.D., family physician

Money from the MMA

Tornado Relief Fund will be donated to St. Peter Community Hospital & Health Care Center and used by the medical staff for such projects as a community forum to help residents recover from the psychological damage caused by the tornadoes. “After a disaster occurs, there are so many tasks that must be done immediately, that the full psychological impact may not hit until much later,” said Kathryn Kramer, M.D., a family physician in St. Peter. “We want to help people deal with the aftermath of the tornado.”

The MMA Tornado Relief Fund has been established through the Minnesota Physicians Foundation, a charitable foundation established by and affiliated with the Minnesota Medical Association.

All contributions are tax deductible. Please make checks payable to the Minnesota Physicians Foundation and write “Tornado Relief Fund” on the memo line. Send your contributions to: 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, Attn: Lorrie Holmgren.

Name _____

Address _____

MPF also accepts VISA, MasterCard, and Discover.

Card Type _____

Issued to _____

Card # _____

Signature _____ Exp. Date _____

Regular Legislative Session Ends; Special Session Called

The unexpectedly turbulent 1998 Minnesota legislative session ended in the early morning hours of April 10—but not for long. Gov. Arne Carlson called an April 20 special session to help Warroad, Minnesota-based Marvin Windows.

The Senate adjourned at the end of the day April 20, after passing four bills—including a bill to help Marvin Windows in a suit against a supplier of an allegedly defective wood preservative. The special session lasted two days longer in the House; lawmakers there ultimately passed three of the four bills passed by the Senate.

One source of debate in the House was a \$12 million spending bill for youth and housing programs, which DFLers had worked out in negotiations with the governor just before the special session. Carlson had earlier vetoed \$59 million spending on such programs; the whittled-down package includes \$4.2 million for the Department of Children, Families and Learning. Money also is earmarked for a program to prevent homelessness, vocational rehabilitation for disabled people, a summer job program for youth, and job training for Hmong and Laotian women.

House Republicans accused DFL senators of lavish spending, saying the \$12 million should go back to beleaguered taxpayers, and refused to supply the 21 votes needed to pass the bills in one day. DFLers accused House Republicans of political grandstanding, arguing that the \$12 million in "crumbs for the children" represents one-tenth of 1 percent of the state budget. The House eventually passed the spending package after extensive debate. All of the 134 House seats are up for election in the fall.

Following is a cursory look at several other pieces of legislation dealt with in the 1998 session, and each bill's current status. For more coverage of the session, see the first issue of *The Physician Advocate*.

- **Omnibus Health and Human Services Bill:** The HHS bill passed after intense, late-night negotiations over an abortion-reporting amendment, which ultimately was included in a modified form. The final version did not, however, include the prohibition on intact dilation and extraction that had been pushed by the House. The package was awaiting the governor's signature as *The Monitor* went to press. Key parts of the \$58 million bill include:

Medical Education and Research Cost (MERC) Funding, \$10 million; Office of Health Care Consumer Assistance, Advocacy & Information, \$100,000; Fetal Alcohol Syndrome (FAS) Research and Education Funding, \$5 million; Breast and Cervical Cancer Screening, \$1.25 million.

In addition, a wide range of policy options are included to allow Minnesota to secure its \$28 million allocation from the federal Children's Health Insurance Program, and the Commissioner of Human Services must study and make recommendations for all Medical Assistance (MA) to be increased by the Consumer Price Index before next session. Physician reimbursement under MA has not been increased in over five years.

- **DEA Number:** Gov. Carlson signed the MMA's legislation limiting the inappropriate use of the Drug Enforcement Agency (DEA) number (Chapter 316).

- **Medical Malpractice Statute of Limitations:** Legislation to extend the statute of limitations for medical malpractice cases, strenuously opposed by the MMA, died in health care committees in both the House and Senate—after being passed by judiciary committees of both bodies. It will likely return next session.

- **Tobacco Tax-Provider Tax Swap:** An amendment to the Omnibus House Tax Bill to raise the tobacco tax 40 cents per pack and eliminate the provider tax—ardently

supported by the MMA—failed on the House floor March 11. The MMA will pursue replacing the provider tax next year.

- **FAS Reporting:** Gov. Carlson's legislation to permit (but thanks in part to efforts by the MMA, not require) physicians to report pregnant patients who are abusing alcohol was signed (Chapter 361).

- **.08 Blood Alcohol Level:** The proposal to tighten Minnesota's drunken-driving standard, strongly endorsed by the MMA, died after a conference committee failed to agree about whether the stricter standard should apply to everyone or just repeat offenders.

- **Any Willing Provider:** Legislation that would have required health plans to include any provider who is willing to meet the plans' credentialing criteria and other requirements was not adopted by either of the health care committees. Also, an any-willing-provider amendment to the Omnibus Health and Human Services Bill on the House floor was stripped in conference committee.

- **Direct Access:** A bill to require health plans to provide "direct access" to chiropractors, optometrists, and advance practice nurses was modified to call for a study to assess potential health plan discrimination against providers and provider groups.

- **Critical Access Hospital Licensure:** Legislation to allow certain rural hospitals to be designated "critical access hospitals" has been signed into law (Chapter 257).

- **Children's Endowment:** An MMA-endorsed proposal to place a constitutional amendment on the ballot this fall to create a permanent endowment for children died due to funding disputes in conference committee.

- **Minimum Age to Purchase Tobacco:** MMA legislation to raise the age at which it is legal to purchase tobacco from 18 to 21 never received a hearing.

- **Tobacco Prohibited in Daycare:** An MMA proposal to require day-care facilities to be smoke-free 24 hours a day (present law requires

Legislation continued on page 40

Community Service Award

The MMA's Community Service Award honors an MMA physician who has an outstanding record of community service. A typical candidate might be a physician who:

- helps make free clinical care available to the needy;
- serves as a public official;
- coaches an athletic team;
- is a leader in promoting cultural or arts activities; or
- is a leader in expanding voluntary health programs.

The Community Service Award will be presented at the MMA Annual Meeting in St. Paul on October 8, 1998.

If you know a physician who qualifies for this award, please fill out the attached nomination form and return it to Karen Tourdot, Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761.

MINNESOTA MEDICAL ASSOCIATION PHYSICIAN AWARD FOR COMMUNITY SERVICE NOMINATION FORM

Qualifications

1. The recipient must be a physician member of the Minnesota Medical Association licensed to practice medicine in the state of Minnesota.
2. The recipient must be living. Awards are not presented posthumously.
3. The recipient must have compiled an outstanding record of community service, which, apart from his or her specific identification as a physician, reflects well on the profession.

Name of nominee: _____

(Home address)

(Business address)

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Describe why this person should receive the MMA Community Service Award: _____

(Supporting information may be attached.)

NOMINATION SUBMITTED BY:

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NOMINATIONS DUE ON OR BEFORE JULY 15, 1998

'2 Smart 2 Smoke' Spring Tour Earns Critical Acclaim

Component medical societies, specialty societies, and clinics throughout Minnesota joined the MMA and the Smoke-Free 2000 Coalition in sponsoring productions of the National Theatre for Children's antismoking play "2 Smart 2 Smoke" in 30 schools throughout Greater Minnesota.

The spring tour began in Cambridge, Braham, and Isanti, where the East Central Minnesota Medical Society and the Memorial Hospital Foundation Minnesota were cosponsors. An article in the *Star* of Cambridge quoted Paul Sanders, M.D., CEO of the MMA and a family physician in Cambridge, about the play.

"Children are starting to smoke when they are very young. Since 1989 smoking among ninth-grade students has increased by 36 percent," Sanders said. "These plays are an excellent way to help kids from beginning an addiction to tobacco that can lead to disease and even death."

A complete list of cosponsors, locations, and dates follows:

- East Central Minnesota Medical Society and the Memorial Hospital Foundation of Cambridge: Cambridge Elementary, Cambridge Middle School, Isanti Middle School, and Braham Elementary, April 2 and 3;

- Stearns-Benton County Medical Society: Roosevelt Elementary in St. Cloud, April 6;

- Central Minnesota Center for Diagnostic Imaging, L.L.C., and John Reisinger, M.D.: St. Augustine School in St. Cloud, April 7;

- CENTRACare Clinic: Lincoln Elementary in St. Cloud, April 8;

- Mid-Minnesota Family Practice: Jefferson Elementary in St. Cloud, April 9;

- Neurological Associates of St. Paul, Noran Neurological Clinic, and the Minneapolis Clinic of Neurology: Jefferson Elementary in Red Wing, April 14;

- Doctors Ought To Care and Rochester Area PTSA: Hawthorne Elementary in Rochester, April 14;

- Brown County Medical Society, Physicians Group of New Ulm, and New Ulm Medical Center: Jefferson Elementary in New Ulm, April 17;

- Minnesota Allergy Society: Jefferson Elementary in Rochester, April 20;

- Minnesota Society of Clinical Oncology: Folwell Elementary in Rochester, April 21;

- Minnesota Academy of Otolaryngology: Dassel Elementary in Dassel, April 22;

- Blue Earth County Medical Society: Washington Elementary in Mankato, April 23;

- American Academy of Pediatrics, Minnesota Chapter: Ripley Elementary in Litchfield, April 28;

- Minnesota Society of Anesthesiologists: Wagner Elementary in Litchfield, April 28;

- Minnesota Academy of Family Physicians: McKinley Elementary in Fergus Falls, April 29;

- American College of Cardiologists, Minnesota Chapter: Cleveland Elementary in Fergus Falls, April 29;

- Headwaters Medical Society: Solway Elementary, Deer Lake Elementary, Smith Elementary, Central Elementary, and Lincoln Elementary in Bemidji, April 30, May 4 and 5;

- Red River Valley Medical Society: Roseau Elementary in Roseau, May 1;

- Upper Mississippi Medical Society: Harrison Elementary in Brainerd, May 7;

- St. Mary's/Duluth Clinic Health System and Lake Superior Medical Society: Lakewood Elementary in Duluth, May 8;

- St. Luke's Foundation and Lake Superior Medical Society: Homecraft Elementary in Duluth, May 11;

- Lake Superior Medical Society: Chester Park Elementary in Duluth, May 12.

"2 Smart 2 Smoke" was developed through funding by Allina Health system for presentation to 162 schools in the Twin Cities area.

Legislation continued from page 38

them to be smoke-free when children are present) also never received a hearing.

- **Coverage of "Off-Label" Drugs:** A bill, supported by the MMA, to prohibit health plans from denying coverage of cancer drugs solely on the basis of whether the drugs are "off-label" has been signed into law (Chapter 301).

- **Naturopaths and Massage Therapists Licensure:** Two legislative proposals to license new groups of providers failed to pass again this year. The first bill would have licensed doctors of naturopathy under the Board of Medical Practice; the second would have licensed massage therapists under a separate licensing board. Neither bill received a hearing in the Senate.

- **Provisional Driver's Licenses:** Legislation to create provisional driver's licenses for kids ages 16 and 17—supported by the MMA as a way to reduce teenage driving accidents—was still awaiting the governor's signature as *The Monitor* went to press.

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The Monitor

MAY 1998

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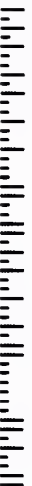
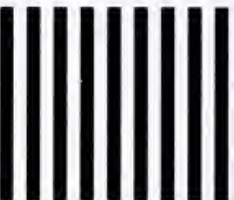
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Epidemiology in Minnesota

Alcohol Epidemiology

Reporting and Collecting Data on Use in Minnesota

Doreen Kloehn, M.A., and Jon Roesler, M.S.



Alcohol

Alcohol epidemiology describes and explains the distribution of alcohol use, abuse, and dependence and associated health and social consequences.

Data are obtained from self-report surveys, alcohol sales figures, vital statistics, hospital records, chemical dependency treatment data, and other sources. Population-based epidemiologic data can help identify areas of greatest risk, guide prevention and treatment initiatives, offer a base to estimate the costs of alcohol use, and provide a means to compare changes in alcohol use and its consequences over time.

These tasks are complicated by 1) frequent under-reporting of alcohol use in self-reports; 2) the need for more screening and better documentation by professionals; 3) changes in alcohol use definitions and diagnostic criteria; 4) the need for a clearer understanding of alcohol's causal or associative role with particular diseases and injuries; 5) interactions with other factors (e.g., smoking) that affect health status; and 6) the need to standardize measures of blood alcohol concentration and intoxication.

The U.S. Department of Health and Human Services reports that national epidemiologic data have shown a downward trend in overall per capita alcohol consumption from the early 1980s through 1993. Recent years

have shown increases in abstinence rates and decreases in heavy drinking and liver cirrhosis mortality. However, survey data indicate that social consequences and dependence symptoms have not changed overall. Analysis suggests that lower levels of drinking also present risks of consequences. Data also show variations in alcohol use by gender, age, ethnic group, and socioeconomic status.

Alcohol epidemiology in Minnesota is characterized by descriptive rather than inferential analysis. It describes the relationships between the agent, host, environment, and time. Alcohol is the most widely used drug in Minnesota and the most frequently cited primary substance problem for persons entering chemical dependency treatment.

ASSESSING ALCOHOL USE IN MINNESOTA

In Minnesota, several population-based surveys assess alcohol use statewide. The Behavioral Risk Factor Surveillance System (BRFSS) survey is a monthly telephone survey of adults conducted by the Minnesota Department of Health (MDH). Annual BRFSS reports include data on abstinence, acute and chronic drinking, and drinking and driving.

Results of the Adult Household Survey of Alcohol and Drug Use will be released this spring by the Department of Human Services. The survey includes data on the

prevalence of alcohol and other substance use, as well as prevalence of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) conditions, to assess the number of people in Minnesota who need treatment.

The Minnesota Student Survey is conducted every three years among students in grades six, nine, and 12. The Department of Human Services and the Department of Children, Families and Learning will collaborate on this year's survey, which includes questions about alcohol use and its consequences. A survey will also be conducted among special student populations in alternative educational, correctional, or treatment settings. Also, University of Minnesota researchers have led an analysis of a national survey of adolescents, which includes alcohol questions.

The Women, Infants and Children program, birth certificates, and the new Minnesota pregnancy assessment form all request information on alcohol use during pregnancy, although reporting problems exist and data may not be reliable.

CONSEQUENCES OF ALCOHOL USE

The consequences of alcohol use can be measured in many ways. The Department of Human Services maintains a chemical dependency treatment outcomes monitoring system to track numbers of people receiving treatment and their outcomes. Birth certificates include an item for fetal alcohol syndrome, although the data are not considered reliable. Death certificate data may include alcohol as an immediate, underlying, or contributing cause of death. Although cancers, digestive diseases, and cardiovascular diseases account for a large proportion of alcohol-related deaths, unintentional injury is the single largest category of alcohol-related deaths, according to a study by the Minnesota Department of Health. Unintentional injury and violence comprise nearly 75% of the estimated costs of alcohol-related mortality. Less data is available on alcohol-related morbidity.

The University of Minnesota Division of Epidemiology is engaged in several studies to assess the effects of public policies on alcohol consumption and problem indicators. These studies include a youth tracking project and an evaluation of injury deaths in seven states that have changed their alcohol control policies.

ALCOHOL USE AND INJURIES

The MDH collects alcohol use data as part of its ongoing injury surveillance system. The MDH Report of Injury form includes a variable on alcohol use before the injury and is used to collect data on brain and spinal cord injuries. The MDH and partners are exploring the form's use for reporting all hospitalized trauma, firearm-related injuries, and agriculture- or work-related injuries.

The Minnesota Medical Association has recommended that patients under the influence of alcohol who are treated for motor vehicle crash injuries be reported to police and sheriff departments. The Minnesota State DWI Task Force has further recommended that those injuries also be reported to the Minnesota Department of Health, as are firearm-related injuries.

With funding from the Centers for Disease Control and Prevention, the MDH is also working with the Minnesota Hospital and Healthcare Partnership to describe the 800,000 injuries treated each year in Minnesota's emergency departments. This project utilizes alcohol use coding from the UB-92 (universal bill).

MDH reporting mechanisms work to the extent that physicians, nurses, and other clinical staff identify and document in the medical record the level of alcohol use and/or intoxication. Medical records frequently lack documentation regarding alcohol use by the injured patient.

Other state departments also report alcohol use at the time of injury. The Department of Public Safety collects data about, and annually describes, the relationship between alcohol and traffic-related injuries (e.g., in 1996, 11% of motor vehicle crash injuries and 36% of the fatalities were alcohol related). The Department of Natural Resources collects and routinely reports similar data for non-traffic, vehicle-related injuries, including snowmobiling, off-road motorcycle and ATV use, and boating; as well as data about hunting-related firearm injuries. The State Fire Marshal Division of the Department of Public Safety collects and reports information about the role of alcohol in burn deaths.

In the foreseeable future we can expect to see the Minnesota Emergency Medical Services Regulatory Board collect and report data on patient alcohol use at the time of injury.

Alcohol is clearly involved in interpersonal violence and other crimes. The Department of Human Services requires child maltreatment reports to indicate alcohol abuse by the perpetrator, victim, or household. Minnesota law requires that probation officers for convicted felons determine whether alcohol or drug abuse was a contributing factor in the offense. Department of Health injury surveillance can address alcohol involvement among victims. A 1996 study showed that nearly 60% of Minneapolis youth homicide victims had detectable levels of alcohol at the time of death. MM

For more information about alcohol use in Minnesota, see the May 1997 Minnesota Medicine article "Alcohol Use in Minnesota: Extent and Cost."

Both authors work in the Center for Health at the Minnesota Department of Health. Doreen Kloehn is a research analyst and Jon Roesler is an epidemiologist.

Etiology, Prevention, and Treatment of Breast, Prostate, Colorectal, and Lung Cancer

Jack S. Mandel, Ph.D., M.P.H., and Martin Oken, M.D.

Cancer

Breast, prostate, colorectal, and lung cancers represent over 50% of all cancers. This year, 10,000 Minnesotans will develop these cancers and 4,400

will die from them. Many of these cases and deaths are preventable. This article provides recent information on what is known about the causes of these cancers, what steps can be taken to prevent them, and the most effective treatment methods. Primary care physicians can play a significant role in educating patients about the known or suspected causes of these cancers and in strongly encouraging patients to undergo proven screening tests for breast and colorectal cancers.

Over a lifetime, one in two men and one in three women will develop an invasive cancer. Of the 1.2 million new cancers and 565,000 cancer deaths expected this year in the United States, over half will be breast, prostate, colorectal, and lung cancers.¹ Five-year survival rates vary from 14% for lung cancer to 90% for prostate cancer. Survival is better for localized cancers than for distant cancers. Only 60% of breast cancers, 59% of prostate cancers, 38% of colorectal cancers, and 15% of lung cancers are localized at diagnosis. The difference in five-year survival rates between localized and distant cancers is considerable, ranging from 100% to 31% for prostate cancer, 97% to 21% for breast cancer, 92% to 8% for colorectal cancer, and 49% to 2% for lung cancer.¹ Despite improvements in early detection, risk-

factor reduction, and better treatment, we can do much better. Primary care physicians can help reduce morbidity and mortality from these cancers.

The University of Minnesota supports a number of cancer research projects. The Division of Environmental and Occupational Health (EOH) in the School of Public Health (SPH) is collaborating with the Virginia Piper Cancer Institute at Abbott Northwestern Hospital in a randomized controlled clinical trial to evaluate screening for lung cancer (chest x-ray), prostate cancer (annual PSA and digital rectal), colorectal cancer (periodic flexible sigmoidoscopy), and ovarian cancer (annual CA-125 and transvaginal ultrasound). The EOH, in collaboration with the VA Hospital and Minnesota Gastroenterology, is also conducting randomized clinical trials to evaluate the benefit of calcium, aspirin, and folate in reducing recurrence rates of adenomatous polyps. The SPH recently completed a trial demonstrating the benefit of a voucher for a free mammogram in increasing breast cancer screening in rural Minnesota.

The University of Minnesota Cancer Center is conducting studies of PEITC as an inhibitor of lung tumorigenesis in rats, isothiocyanate and nitrosamine carcinogenesis, the role of Rb and cyclins in lung cancer, lactation-induced reduction in breast cancer risk, and the preventive effects of phytoestrogens on breast cancer.

The Piper Breast Center at the Virginia Piper Cancer Institute is studying the effect of fat reduction on recur-

rence rates in resected breast cancer. The institute is also investigating the significance of mouse mammary tumor virus in breast tumors from recently diagnosed patients. In collaboration with the University of Minnesota super-computer laboratory, the institute is developing unique three-dimensional models of estrogen receptors on breast cancer cells. The University of Minnesota, the Virginia Piper Cancer Institute, and a wide spectrum of quality community cancer programs in the state participate in many cooperative group clinical trials (ECOG, CALGB, NSABP), including the recently reported Breast Cancer Prevention Trial.

BREAST CANCER

ETIOLOGY

The etiology of breast cancer is not known, although many risk factors have been identified. These include early age at menarche, late age at menopause, late age at first pregnancy, hormone replacement therapy, and obesity. Physical activity and low-fat diet may be protective.

PREVENTION

Annual mammography with clinical examination in women aged 50 and over reduces breast cancer mortality. Screening average-risk women under age 50 is controversial because of a lack of definitive evidence demonstrating mortality reduction. A trial evaluating primary prevention with tamoxifen in high-risk women showed a 45% reduction in breast cancer incidence among high-risk women taking tamoxifen. Because of the significant increase in thrombophlebitis and pulmonary embolism and an increased number of endometrial cancers, further evaluation is needed before definitive recommendations for tamoxifen prophylaxis can be made.

TREATMENT

With proper treatment, fewer than 30% of breast cancer patients will die of their disease. For ductal carcinoma in situ or early-stage invasive breast cancer that has not spread beyond the regional lymph nodes, treatment involves either mastectomy or lumpectomy. The latter is followed by radiation therapy to the breast. With tumors larger than 1.0 cm in maximum diameter or with lymph node involvement, adjuvant chemotherapy is usually indicated. Standard regimens include cyclophosphamide, methotrexate, and 5-FU (CMF) and Adriamycin with cyclophosphamide (AC). Hormonal manipulation such as tamoxifen therapy may be useful after chemotherapy for patients with hormone receptor-positive cancers and may be used in place of chemotherapy in some postmenopausal patients with receptor-positive tumors and low-to intermediate-risk disease. Patients with distant metastases are treated with chemotherapy or hormone manipulation, often with good temporary objective and

palliative results for months to years. High-dose therapy with stem cell rescue is under clinical investigation for patients with resectable disease and multiple positive lymph nodes and for carefully selected patients with distant metastatic disease.

PROSTATE CANCER

ETIOLOGY

Prostate cancer is the most common cancer among men. The rapid increase in incidence during the past decade is largely due to increased serum prostate-specific antigen (PSA) testing. The death rate has not paralleled this increase. The etiology of prostate cancer is unknown. It is rare before age 50 but increases rapidly with age in men over 60. It is more frequent in African-American men than white men and is less frequent in Asian-American men. No lifestyle risk factor has been strongly associated with the disease. Areas needing further research include dietary factors (fat intake, vitamins), hormonal influences, and genetic factors.

PREVENTION

Despite the absence of definitive data, a case can be made for reducing fat intake and increasing physical activity, largely on the basis of the benefit to overall health. Trials of finasteride as a preventive agent and PSA as a screening test are in process.

Secondary prevention through screening is controversial. Digital rectal examination, which has a low sensitivity and poor predictive value, is not recommended as a mass screening test. PSA testing, although widely used, has not been proven effective. Both the specificity and positive predictive value of PSA are relatively low. Mass screening of PSA in average-risk, asymptomatic men is hard to justify in view of the large proportion of latent cancers detected and subsequent surgical interventions. Should physicians choose to use PSA, it is important to inform patients of potential consequences.

TREATMENT

Most patients with microscopic cancer and limited involvement of the gland (discovered incidentally at transurethral resection for benign prostatic hypertrophy) are followed clinically with no therapy. For patients whose disease is confined within the prostate capsule, treatment is typically intended to cure, using either radical prostatectomy or external-beam radiotherapy. There is renewed interest in brachytherapy with the newer techniques, but long-term follow-up is not yet available. Survival for the first 15 years is similar between surgery and external-beam radiotherapy. Because residual cancer is frequently found after radiotherapy, surgery is often preferred for patients under age 70 and radiotherapy for older patients. If disease is outside the gland capsule, hormone

therapy is used, often with radiotherapy. Hormone therapy consists of androgen deprivation by bilateral orchiectomy or through the use of an LHRH analog, often with an antiandrogen to block the adrenal androgens as well. Metastatic disease is also treated with androgen deprivation, often for two years or more. Chemotherapy may be helpful in some patients with disease refractory to hormone manipulation.

COLORECTAL CANCER

ETIOLOGY

The etiology of colorectal cancer is not known. Increased dietary fat correlates with an increased risk of colon cancer, and fruits and vegetables and physical activity with decreased risk. There may be a protective effect from calcium. Data on nonsteroidal anti-inflammatory drugs are contradictory. Randomized controlled clinical trials of aspirin are underway at the University of Minnesota.

PREVENTION

Primary prevention could probably be achieved through decreased fat consumption, increased fruit and vegetable consumption, increased physical activity, and possibly calcium supplementation, as well as by removal of adenomatous polyps, precursors to colorectal cancers.

Screening is effective. Three randomized controlled trials involving over 250,000 participants have shown significant colorectal cancer mortality reduction from both annual and biennial fecal occult blood testing (FOBT).²⁻⁴ Annual FOBT of the asymptomatic population aged 50 and over will reduce colorectal cancer mortality by at least 33%.²

Periodic flexible sigmoidoscopy screening is probably effective, although the extent of the benefit is unknown. Flexible sigmoidoscopy is a more sensitive test than FOBT but only identifies lesions in the distal colon. Up to half of neoplastic lesions could be missed with flexible sigmoidoscopy. A combination of annual FOBT and five-year flexible sigmoidoscopy for average-risk individuals aged 50 and over could be justified from available data. The incremental benefit of flexible sigmoidoscopy over FOBT is not known but is presumed to be greater than zero. A randomized trial of flexible sigmoidoscopy screening is underway at the University of Minnesota and the Virginia Piper Cancer Institute.

Colonoscopy is recommended for high-risk individuals, including those with a significant family history of colorectal cancer, but the optimal frequency is not known.

TREATMENT

The primary treatment for colorectal cancer is to resect the segment of bowel containing the tumor along with the adjacent mesentery and draining lymph nodes. If the

cancer is in the distal 5 cm of the rectum, abdominoperineal resection and permanent colostomy may be required. For most patients whose disease is confined to the bowel wall, without peritoneal, nodal, or distant spread, long-term survival exceeds 80% and no further treatment is indicated.

Patients with lymph node involvement (Dukes C) benefit from adjuvant therapy. In colon cancer, this commonly consists of combinations of 5FU with levamisole or leucovorin. Patients with rectal cancer and deeply penetrating disease or involvement of the regional lymph nodes (stage II or III, Dukes B2 or C) should undergo adjuvant therapy. For postoperative adjuvant therapy, chemotherapy with 5FU by prolonged continuous infusion may be employed. During a portion of this infusion, the patient receives simultaneous radiation therapy to the rectum. Preoperative radiation has also been used, but its combination with chemotherapy is less well defined. Metastatic disease may be treated with 5FU, either by continuous infusion or with leucovorin. CPT-11 is a new drug that may be used to treat patients with disease refractory to 5FU.

LUNG CANCER

ETIOLOGY

Up to 90% of lung cancers are attributed to smoking. Other risk factors include exposure to asbestos, arsenic, chromates, polycyclic hydrocarbons, and ionizing radiation. A diet high in fruits and vegetables is associated with lower rates of lung cancer.

PREVENTION

Primary prevention can be achieved through smoking cessation. Reducing occupational exposure to known lung carcinogens will also reduce the incidence. There is no proven screening test for lung cancer. Studies of sputum cytology and chest x-ray found no significant lung cancer mortality reduction, although there was improvement in the stage at diagnosis and in the survival rate in screened individuals compared with controls.⁵⁻⁹ Based on existing data, screening for lung cancer is not recommended. A randomized controlled trial of annual chest x-ray in men and women aged 55 to 74 is ongoing at the University of Minnesota and the Virginia Piper Cancer Institute.

TREATMENT

The treatment of small cell lung cancer centers around chemotherapy. For patients with extensive disease, chemotherapy alone is the standard, and cisplatin with VP-16 is the most commonly used regimen. Patients with limited disease are treated with cisplatin and VP-16 with

CANCER continued on page 71

Trends in Cardiovascular Disease in Minnesota

Russell Luepker, M.D., M.S.

Cardiovascular Health

Age-adjusted mortality from the major cardiovascular diseases—coronary heart disease and stroke—has fallen for several decades. This trend, which began in the mid-1960s, continues for coronary heart disease, with a national 2% to 3% annual decline among both men and women.

In Minnesota, the slope of the decline in mortality parallels that of the entire country, although rates in this state are significantly lower for both coronary heart disease and stroke. Detailed data for Minnesota are based on the National Institutes of Health-supported Minnesota Heart Survey.¹⁻³ This study has evaluated cardiovascular disease trends since the early 1970s and includes mortality, morbidity, and population risk assessments at regular intervals. Many observations from the study are important for Minnesota and the nation.^{4,6}

Among those observations is the recognition that while age-adjusted mortality is falling, resulting in an increased life span, absolute mortality has fallen only slightly. The burden of disease is undiminished—it now happens at later ages in life. This has a clear impact on clinical practice and health care costs. In addition, while the number of initial myocardial infarctions has fallen, recurrent (second and third) events have risen as more people survive their first heart attack. This results in more chronic congestive heart failure, a diagnosis that has doubled or tripled in the last decade.⁷

The overall fall in mortality hides another change: the difference between in- and out-of-hospital deaths. Mortality within hospitals has fallen dramatically for cardiovascular diseases. Out-of-hospital deaths (the majority of deaths) have also fallen, but not at the same rate as in-hospital mortality.¹⁻⁴ Out-of-hospital death is a major problem in Minnesota and the nation.

There have also been dramatic shifts in the care of individuals with acute and chronic cardiovascular disease. Interventional cardiology procedures (PTCA and CABG) are commonplace.⁸ There is increased and appropriate use of aspirin and beta blockers for post-myocardial infarction.⁴ Cardiac rehabilitation programs, control of hypertension, and smoking cessation in patients with chronic cardiovascular disease have all increased.

Striking changes have also occurred in the major risk factors for cardiovascular disease. Cigarette smoking has fallen significantly over the past two decades to levels below the national averages.⁴ However, rates are not as low as in California, where a mass education and cessation campaign supported by cigarette taxes has dramatically reduced smoking.

Blood cholesterol in the population has also been falling an average of .5 µg/dl per year over the past two decades. This population-wide shift is largely the result of changes in dietary habits, including decreased use of animal fat and increased use of vegetable fats.⁹

On the negative side, while detection and hyperten-

sion control improved in the 1980s, this trend appears to have reversed in this decade. Increasing numbers of patients are not treated for their hypertension.¹⁰ Age-adjusted stroke mortality rates, which had fallen for many years in Minnesota, are now rising again. Similarly, weight, adjusted for height, has risen steadily in the population for several decades.⁴

While many trends in cardiovascular disease in Minnesota are favorable, others may signal a growing disease burden in the future. These observations are important as clinicians strive to reduce morbidity and mortality. **MM**

Russell Luepker is head of the Division of Epidemiology, University of Minnesota School of Public Health.

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Issues in Environmental Health Epidemiology

John L. Adgate, Ph.D., Deborah Swackhamer, Ph.D., Donald Vesley, Ph.D.

Environmental Health

Environmental health epidemiology examines links between environmental exposures and health effects in human populations. This article describes three important environmental

health issues of current interest to the teaching or research programs in the Division of Environmental and Occupational Health in the University of Minnesota School of Public Health.

AIRBORNE PARTICULATE MATTER

In one of the most momentous environmental decisions of the decade, last year the Environmental Protection Agency (EPA) proposed new National Ambient Air Quality Standards for particulate matter (PM). PM is a generic term; it applies to a broad class of chemically and physically diverse particles varying from 0.001 μm to 100 μm that exist as discrete particles, both liquid droplets and solids, suspended in air. Current EPA standards regulate the mass of PM per unit volume in air; the new standards extend this paradigm to smaller particles than have been regulated before. The new standards aim to control so-called fine particles, i.e., those 2.5 μm or less in aerodynamic diameter ($\text{PM}_{2.5}$).

PM originates from natural sources like soil, dust, fires, and plant pollen; many particles <2.5 μm originate from manmade sources, especially combustion, as well as transportation and a wide range of agricultural and

industrial practices. The new $\text{PM}_{2.5}$ standards explicitly assume a causal relationship between an individual's exposures to fine particles and resulting disease (e.g., asthma, emphysema, bronchitis) and daily mortality. Politicians, scientists, and stakeholders disagree about whether the scientific evidence supports the new standards. Most important, it is unclear whether the health benefits of the new standards justify the economic costs of implementation, which are estimated at hundreds of billions of dollars.

To support the new standard, the EPA cites a number of time-series epidemiological studies that have shown weak, but statistically significant, associations between urban particle concentration and daily mortality counts.¹ Such ecological studies have often been criticized for not meeting causality criteria; i.e., the studies do not demonstrate cause-effect relationships because they use central site data to make inferences on individuals' health. Not only do particle concentrations vary spatially over a geographical region, but such measurements do not represent personal exposures in a population that spends a large part of its time indoors. Studies have shown that most people spend more than 90 percent of their time indoors—at home, work, or elsewhere. Additionally, some studies monitoring individuals indicate that personal exposures are significantly higher than those measured at a central outdoor site—that is, human activities generate a “personal cloud” of particles.² These criti-

cisms illustrate the need to collect personal monitoring data to validate risk estimates and toxicological data to shed light on the mechanisms by which fine particles exert adverse effects.

Because of the scientific uncertainties of the new PM_{2.5} standards, as well as their economic and environmental significance, the Division of Environmental and Occupational Health at the University of Minnesota's School of Public Health is developing initiatives to address both the science and policy issues associated with PM regulation. Goals include 1) laboratory studies to examine the relationship between "very fine" particles (those ranging from approximately 0.01 µm to 0.5 µm) and cellular response; 2) field studies to elucidate the relationship between exposure measurements collected by fixed-point outdoor monitors and indoor and portable personal monitors; and 3) policy analyses to examine regulatory options, compliance costs, and the effect of using novel exposure metrics to express PM standards.

IRRADIATION OF FOOD

Recent reports of foodborne illness outbreaks from widely distributed products have prompted the search for fail-safe technologies to protect the public (see the Cover Story, page 18). Previous examples of such technologies include pasteurization of dairy products and the retort process in the canning industry. Many environmental health professionals believe that food irradiation is a similar technology.

Irradiation has been approved for many years for some products, including poultry, pork, fruits, vegetables, grains, and spices, although it has been used sparingly. Since December 1997, it has also been approved for ground beef, a decision that has sparked a heated debate. Opponents claim that irradiation (accomplished primarily with gamma radiation from cobalt-60 or cesium-137) destroys essential vitamins and creates potentially carcinogenic radiolytic byproducts such as benzene. Additionally, they cite the need for expensive facilities, which will add to the nuclear waste problem and increase the probability of nuclear accidents.

Adherents dispute these claims, emphasizing the proven ability of gamma irradiation to destroy potential pathogens with a higher degree of reliability than suggested alternatives such as steam and disinfectant rinses. Supporters say that vitamin and nutrient depletion is trivial, as are radiolytic byproducts. They also cite the safety track record of the nuclear industry in the United States over the last 50 years (although the concern over additional nuclear waste is harder to contest).

The scientific community largely supports irradiation, while environmental activists and nuclear energy critics oppose it. Food irradiation has been very slow to materialize on a large scale, mainly because of lingering public distrust of radiation and a resulting lack of

consumer acceptance. The high cost of facility installation is also a factor, particularly in the face of consumer reluctance. In the past, initial public opposition to environmental interventions eventually gave way to acceptance after benefits were shown to outweigh perceived dangers. Thus, chlorination of drinking water and pasteurization of dairy products have long been institutionalized in our society (although drinking water fluoridation has yet to make a similar breakthrough). Whether or not food irradiation eventually becomes routine remains to be seen. Fear of the "mysterious" concept of radiation remains strong in our society. Perhaps it will take additional large-scale outbreaks of foodborne disease to convince the public that a practical solution is available and should be widely employed.

The Division of Environmental and Occupational Health in the University of Minnesota's School of Public Health is expanding its program in environmental microbiology to include a new emphasis on food safety teaching and research.

WHY CAN'T WE EAT THE FISH?

As residents of the Land of 10,000 Lakes, Minnesota anglers have ample opportunity to catch and consume fresh fish. However, chemical contaminants in fish can pose a health risk. The Minnesota Department of Health (MDH) issues Health Consumption Advisories offering guidance on which fish are safe to eat and in what quantities for most lakes in the state.³ Many other states have similar programs. Some anglers ask why these advisories are needed, some ignore them because they have had no ill effects from eating fish all their lives, and still others don't know the advisories exist. Health officials and health care providers should be aware of these advisories and be able to answer patients' questions about them. Understanding the processes that lead to chemical accumulation in fish and how the advisories are developed is also useful.

Certain chemicals with low water solubility and a high resistance to metabolism accumulate in the fat and lipids of fish tissue.⁴ These chemicals include polychlorinated biphenyls (PCBs), polychlorinated dibenzo-p-dioxins and dibenzofurans (PCDD/Fs), methyl mercury, and chlorinated pesticides such as DDT and toxaphene. Methyl mercury is the biggest concern in inland lake fish, while PCBs and toxaphene are of most concern in Lake Superior fish.

Although fish are exposed to these hydrophobic chemicals from water, most of their exposure comes from the food they eat. Uptake into tissue is very fast, but depuration is very slow, resulting in a magnification of the chemical in each trophic level.⁵ Fish are at the top of the aquatic food chain and thus have tissue chemical concentrations 100,000 to 10 million times greater than the water in which they live. One meal of Lake Superior

trout will expose an individual to more PCBs than a lifetime of drinking Lake Superior water. Food preparation techniques such as skinning and filleting reduce the organic chemical concentrations about 25 percent but do not reduce mercury levels, as this contaminant resides in muscle tissue.

Most North Americans are exposed to these chemicals through fish consumption. Minnesotans eat more fish than the average American and, thus, have greater exposures. Other populations with potentially higher exposures are Native Americans, commercial fishers, and charter boat operators.

The MDH calculates its Health Consumption Advisories from estimates of exposure (average Minnesota fish consumption and concentration of chemicals in fish) and the maximum allowable dose based on human and animal toxicity studies. For instance, epidemiological research has demonstrated behavioral, developmental, and learning deficits in children born to mothers who consumed moderate amounts of Lake Michigan fish.⁶⁻¹² That is why the advisories have separate recommendations for women of childbearing age. The advisories are not meant to discourage fish in the diet, but to protect consumers' long-term health and their children's health.

The environmental chemistry program in the Division of Environmental and Occupational Health is conducting an extensive research program on potentially harmful chemicals in the Great Lakes. The program is designed to explain the mechanisms of biomagnification in the food web of top sport fish and to develop quantitative models that help predict chemical concentrations in fish.¹³⁻¹⁷ These models are useful for estimating human and wildlife exposure to chemicals from fish consumption. MM

John Adgate, assistant professor, Deborah Swackhamer, associate professor, and Donald Vesley, professor, are in the Division of Environmental and Occupational Health, School of Public Health, University of Minnesota.

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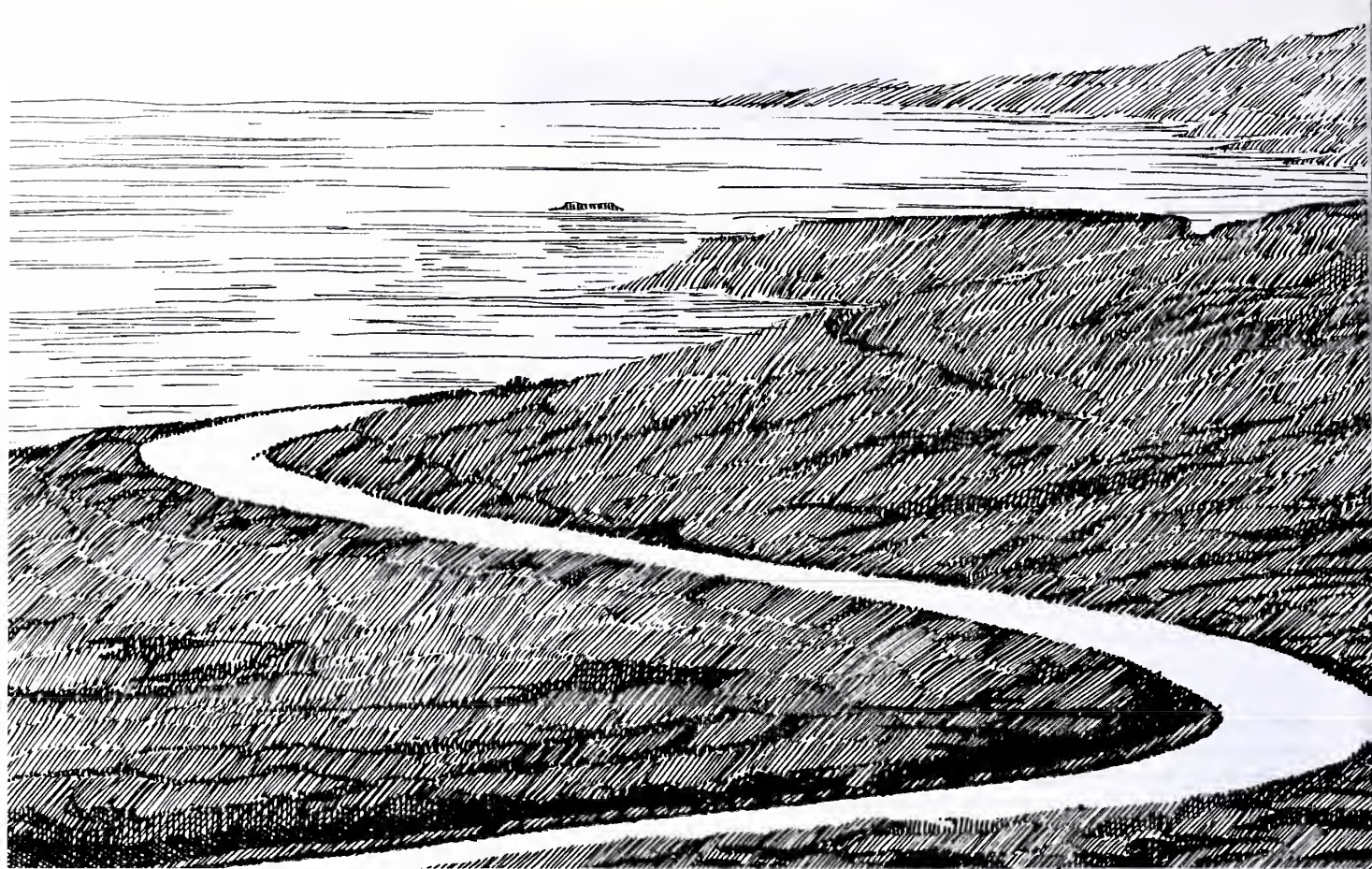
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Alan R. Lifson, M.D., M.P.H.

Infectious Diseases

Minnesota, the United States, and the entire world are seeing the emergence or reemergence of a variety of new and old infectious diseases. Whether we travel to exotic foreign countries or go no farther than the corner grocery store, we are all potentially at risk for infection from a wide variety of communicable microorganisms. As the next millennium approaches, communicable infections will remain significant causes of disease and disability. In addition to acute illnesses, a variety of chronic diseases, such as peptic ulcers, some cancers, and possibly even atherosclerotic cardiovascular disease, are increasingly recognized as having an infectious etiology.

To meet this rising tide, our program in the Division of Epidemiology, University of Minnesota School of Public Health, is training physicians and other graduate students in the principles and practice of infectious disease epidemiology. All epidemiology graduate students receive in-depth training in epidemiologic methods, including study design, data collection, and computer-based statistical analysis. In addition to the core curriculum, additional classes are available for students with a specific interest in infectious diseases. A survey class covers common infectious diseases, modes of transmission, prevention strategies, surveillance, outbreak investigation, and other key concepts. In other courses, students learn about advanced analysis of infectious

disease data, including mathematical modeling, and international health, covering topics like disease control strategies in developing countries. Additional classes being planned will address such topics as the role of the laboratory in outbreak investigations. Of particular relevance is the increasingly important use of DNA fingerprinting and other molecular techniques to investigate outbreaks and disease transmission in the community and in institutions such as hospitals.

In addition to formal classroom teaching, students learn research skills by participating with faculty on specific research projects. Research studies on which students have collaborated include investigations of tuberculosis and HIV in injection drug users; sexually transmitted diseases and abnormal cervical cytologies among economically disadvantaged youth; and high-risk sexual behaviors among homosexual and bisexual men and women. International health represents another major interest of both students and faculty. We have conducted activities or are developing collaborations in Mexico, Brazil, Argentina, Ukraine, Romania, Zimbabwe, South Africa, and Vietnam.

Good relationships within and outside the university are key to the success of our training and research program. Within the university we are studying amebiasis with the Department of Medicine and are working with the Department of Laboratory Medicine and Pathology to evaluate human papillomavirus. One of the

most important components of our training program is based on a strong collaboration with the Minnesota Department of Health. One exciting project (conducted with the Health Department's Acute Disease Epidemiology Section) allows students to carry "on-call" beepers and participate in outbreak and acute disease investigations.

Physicians in the community have many opportunities to interact with epidemiology students and faculty. MPH students may work with physicians on supervised field projects, gaining practical experience in health care settings. Information collected by community-based physicians can also be a valuable source of data for

student or faculty research projects, such as an evaluation of drug resistance among AIDS patients on antiretroviral therapy.

New and old infectious diseases will continue to emerge, bringing many challenges for the health community. With the support and collaboration of many colleagues throughout Minnesota, our training and research program in the Division of Epidemiology is helping to meet these challenges. **MM**

Alan Lifson is an associate professor in the Division of Epidemiology, School of Public Health, University of Minnesota.



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Injury Epidemiology

Prevention and Control of a Major Public Health Problem

Susan Goodwin Gerberich, Ph.D., and Nancy Nachreiner

Injuries

Injury, both unintentional and intentional, is the leading cause of years of potential life lost in the United States,^{1,2} accounting for more years lost than

cancer and cardiovascular diseases combined. The three leading causes of injury-related deaths are motor vehicle traffic (29%), firearms (24%), and poisonings (11%).

In 1995, 147,891 people in the United States died as a result of unintentional and intentional injury (51.5/100,000 population); in Minnesota, this rate was approximately 49.1/100,000 population.³ In every age group except infancy, death rates were higher for males than for females; overall, the rate for males was 2.62 times higher. In the same year, there were 37 million visits to emergency departments to treat injuries, representing 37% of all emergency department visits.⁴ Injury and its consequences account for a large percentage of health care spending in the United States, estimated at \$325 billion in 1991.⁴

UNINTENTIONAL INJURY

In 1995, 90,402 people in the United States died as a result of an unintentional injury (34.4/100,000 population),⁴ comprising about 60% of the fatal injuries; a similar rate of unintentional injury was identified in Minnesota in 1996 (34.9/100,000 population).³ Overall, the unintentional injury rate for males is approximately two times greater than that for females. Leading

causes of unintentional injury were motor vehicle traffic, poisonings, and falls; only 3% of firearm deaths are classified as unintentional.

INTENTIONAL INJURY

Violence has been identified as the intentional use of physical force, either against another person or against oneself, that results in, or has a high likelihood of resulting in, injury or death.⁵ Of the 10.9 million violent crimes reported in the United States in 1994, 4.7 million were committed against women.⁴ The spectrum of violence ranges from harassment to death, with both physical and emotional consequences. Nationally, an average of 65 people die each day from interpersonal violence, and more than 6,000 are physically injured.⁶ In Minnesota in 1996, violent crimes included 7,931 aggravated assaults, 49,763 other assaults,⁷ and an estimated 132,000 domestic violence cases (personal communication, Department of Corrections, 1997). Adolescents and young adults in particular have a high risk of death and injury from violence. In 1988, an estimated 1,000 to 2,000 children died from abuse and neglect and, based on earlier data, at least 1.6 million children experienced some form of nonfatal abuse or neglect.^{6,8} In Minnesota in 1995, 12,483 cases of child maltreatment were reported (personal communication, Minnesota Department of Human Services).

Homicide, accounting for 22,552 deaths in 1995

Current Research and Training Activities

- Etiology and Consequences of Injuries Among Children in Farm Households: A Regional Rural Injury Study; Susan Goodwin Gerberich, Ph.D., principal investigator
- Violence Prevention Research Initiative; Susan Goodwin Gerberich, Ph.D., principal investigator
- Risk Factors for Assaults Among Nurses; Susan Goodwin Gerberich, Ph.D., principal investigator
- Risk Factors for Injury Among Veterinarians in Minnesota; Christine Gabel, D.V.M, principal investigator
- Work-Related Physical Assault; Wanda LaMar, M.D., M.P.H., principal investigator
- Costs of Work-Related Assaults in Minnesota; Patricia M. McGovern, Ph.D., principal investigator
- Epidemiological Study of Marijuana and Health: Injury Risk Factors; Susan Goodwin Gerberich, Ph.D., Stephen Sidney, M.D., principal investigators
- Occupational Injury Epidemiology and Control Program; Susan Goodwin Gerberich, Ph.D., director, George Maldonado, Ph.D., director, multiple faculty members. This program provides academic and research training relevant to occupational injury epidemiology and control; includes violence in the workplace.

Members of the Center for Violence Prevention and Control and the Regional Injury Prevention Research Center have also been involved in the following studies: the association between domestic violence and unintended pregnancy; alcohol-related problems; the social service response to child maltreatment and woman battering; work-related violent victimization;¹³ brain injury;¹⁴ tractor-related injuries;¹⁵ dairy operation-related injuries;¹⁶ and machinery-related injuries.

(8.6/100,000 population), is the second leading cause of death in the United States for people aged 15 to 34⁴ and is the leading cause of death for young African-American males;⁹ the homicide rate in Minnesota in 1994 was 3.2/100,000 population.³ Overall, males' homicide rate is three times that of females; at ages 15 to 19 and 20 to 24, homicide rates for males were five to six times those

for females.⁴ Nonfatal assault is a higher risk for males and females aged 12 to 24 years than for any other age group.¹⁰ Homicide in the workplace is the second major cause of occupational death; although males have the highest rate of workplace-related homicide, it is the leading cause of death for women in the workplace.^{11,12} Among all firearm injury deaths, 43% are classified as homicides.

In 1995, suicide accounted for 31,284 deaths (11.9/100,000 population); 51% of all firearm injury deaths were identified as suicides. The suicide rate in Minnesota in 1995 was similar to the national level (11/100,000 population).³ Males' risk of suicide is at least four times greater than that of females.

EPIDEMIOLOGICAL MODEL

Injury epidemiology is the study of the distribution of injuries in populations and risk factors related to these injuries.¹ The core components of the injury epidemiology model include the host (the person injured), the agent of injury (e.g., mechanical, chemical, thermal, electrical energy), the vector or vehicle, and environmental factors. As in chronic and acute disease epidemiology, applying the epidemiological model enables researchers not only to determine the magnitude of the problem, but also to help identify risk factors—information critical for developing prevention and control strategies. This model serves as the basis for a variety of research efforts at the Regional Injury Prevention Research Center (RIPRC) and the Center for Violence Prevention and Control (CVPC) at the University of Minnesota.

Research conducted through the RIPRC addresses a diverse range of injury problems, while that conducted through the CVPC specifically addresses violence, including work-related violence. Researchers at these centers collaborate with experts from multiple disciplines and various institutions. Examples of current research and relevant training activities are described in the sidebar (left).

Injury, both intentional and unintentional, has been identified as a major public health problem; staggering statistics indicate the extent of this crisis. Using the epidemiological model and multidisciplinary research teams is integral to conducting research that will enable the prevention and control of injury. MM

Susan Goodwin Gerberich is an associate professor and director in the Regional Injury Prevention Research Center, the Center for Violence Prevention and Control, and the Occupational Injury Epidemiology and Control Program, Division of Environmental and Occupational Health, School of Public Health, University of Minnesota. Nancy Nachreiner is a research assistant in the Center for Violence Prevention and Control. The Center for Violence Prevention and Control can be accessed on the World Wide Web at: <http://www.umn.edu/cvpc/>

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Occupational Epidemiology in Minnesota

David Parker, M.D., M.P.H.

Occupational Health

Each day, almost 3 million Minnesotans go to work. On average, between one and two people in the state die at work every week, eight to 10 people lose a finger, 10 to 20 develop a work-related cancer, and approximately 3,000 sustain an injury. The number of cases of work-related asthma, noise-induced hearing loss, and other chronic conditions is unknown. In addition, no good estimates are available of the number of workers who sustain serious traumas such as brain or spinal injury.

Workplace injuries and illness in the United States cost over \$1.2 billion annually, although estimating those costs is difficult. Often the only source of such information is workers' compensation claim files, which underrepresent the actual costs of occupational illness in the community.

Understanding how the workplace affects health is crucial in assuring that workers are able to perform their jobs safely and enjoy a retirement unmarred by work-related disabilities. However, understanding the causes and prevention of work-related injury and illness is complex and involves numerous disciplines, including industrial hygiene, biostatistics, medicine, and toxicology. Integrating these disciplines is at the heart of occupational epidemiology.

Occupational epidemiology has been defined as the "study of the effects of workplace exposures on the

frequency and distribution of diseases in the population."¹ Although occupational epidemiology overlaps with other areas of the field, many characteristics set it apart. Occupational epidemiologists must evaluate exposure (presence of a substance), dose (amount of exposure), and at times body burden (amount of a substance that is retained). This often entails trying to recreate or estimate levels of exposure that may have taken place many decades earlier. Although many diseases are unique to the work environment (i.e., mesothelioma, silicosis), most resemble those found elsewhere (i.e., asthma, lung cancer). This leaves the epidemiologist continually trying to understand the relationship between a known or hypothesized exposure and a possible dose-response relationship. In this regard, duration of employment is often used as a surrogate for known exposure.

At the state level, occupational health and safety falls under the auspices of both the Minnesota Department of Health (MDH) and the Department of Labor and Industry. Employers are required to file a first report of injury for employees who suffer an injury that results in medical care other than first aid or missed work. Department of Labor data often serve as the basis for setting workplace health and safety policy. These data, however, are compiled for claims administration not surveillance. As such, their utility for surveillance purposes has been called into question by the National Academy of Sciences.²

Recognizing the limitations of workers' compensa-

tion and other administratively compiled data, the National Institute for Occupational Safety and Health (NIOSH) funded the Sentinel Event Notification System for Occupational Risks (SENSOR) system. State departments of health are responsible for developing SENSOR systems. The MDH is in its sixth year of SENSOR funding to compile data on work-related amputations; in addition, NIOSH funds the MDH to compile surveillance data of work-related fatalities, elevated blood lead in adults, and childhood agricultural injury.

The MDH periodically has conducted cohort studies to help employers evaluate their work force. Such studies typically arise out of concern about an increase in work-related cancer within a specific work site or suspected work-related exposures. The MDH has also been involved in the mass screening and notification of workers.³

The Division of Environmental and Occupational Health in the University of Minnesota's School of Public Health conducts occupational epidemiology studies to evaluate etiologic factors of disease in specific workplaces and in specific professional groups. These studies are retrospective cohort studies of mortality or morbidity of cohorts ranging from a few thousand to 150,000 people, or case-control studies assessing the association between specific diseases and occupations or exposures.

A retrospective cohort study of 150,000 radiologic technologists, for example, evaluates the relationship between long-term, low-dose radiation exposure and cancer incidence and mortality. To date, a number of findings have been published, including generally lower than expected rates for all cancers. An exception was a significantly elevated breast cancer rate among female radiologic technologists employed before 1940, when radiation doses were likely highest. This study will continue through the year 2000.

A number of occupational cohorts are being studied in three states, including North Carolina, Idaho, and Minnesota. These studies focus on a variety of work-related exposures, including lithium, asbestos, dust, and fluorochemicals. Interim results from some of these studies have been published; many of them are still in progress.

Nearing completion is a four-state (Minnesota, Iowa, Wisconsin, Michigan) case-control study of gliomas, focusing on agricultural chemicals and other work-related exposures. This study, prompted by the observation that brain cancer rates were higher in rural areas, will be one of the largest case-control studies of gliomas ever done, involving about 1,000 cases and 2,000 controls.

The Division of Environmental and Occupational Health will also embark on a new study to evaluate pesticide exposures in farmers, part of an ongoing evaluation of agricultural health and safety.

Occupational epidemiology in Minnesota includes a broad range of work-related problems in both farm and industrial settings. Although work-related morbidity is high, few resources are devoted to understanding how work affects Minnesotans' health. Careful examination of the causes of occupational injuries and illness help dispel the myth that these are natural, unpreventable consequences of work.

MM

David Parker is an occupational epidemiologist with the Minnesota Department of Health and a physician at Park Nicollet Medical Center/Health System Minnesota. He served as guest editor for this issue of Minnesota Medicine.

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Reducing Smoking among Minnesota Teens in Managed Care

Harry A. Lando, Ph.D., and DeAnn Lazovich, Ph.D.

Smoking

In 1995, 34.8% of ninth-through 12th-graders in the United States reported smoking in the past month, a dramatic overall increase of 27% since 1991.¹ In

Minnesota, past-month smoking for ninth- and 12th-graders exceeded the national estimates.² Although extensive research has been conducted to reduce adolescent smoking, previous studies largely focused on preventing smoking onset and targeted younger adolescents.

Most interventions have taken place in schools, a setting that provides ready access to adolescents. But school-based tobacco cessation studies have not proven effective. They have been hampered by difficulty in recruiting adequate numbers of tobacco-using adolescents and failure to retain and engage participants throughout the intervention, especially if it is required for adolescents caught smoking at school.

Minnesota researchers have recently undertaken trials funded by the National Institutes of Health that include a smoking-cessation component. These interventions are designed to reach adolescents in managed care rather than school settings. A summary of these studies follows.

Smoking Prevention and Cessation Among Older Adolescents, DeAnn Lazovich, Ph.D., Principal Investigator

This study focuses on both cessation and prevention. It is a randomized controlled trial to assess the effectiveness of

a multicomponent intervention strategy to reduce prevalence of past-month smoking by 1) changing attitudes about smoking among adolescents aged 14 to 17, and 2) providing cessation assistance for adolescents who smoke. A total of 3,000 adolescents who are dependents of members of large managed care organizations and who respond to a mailed survey will be randomized to receive either the multicomponent intervention or usual care.

The intervention will take place over two years and will consist of 1) youth action teams, in which teens will participate in projects that support not being a smoker; 2) attractive postcards with antismoking messages sent to all adolescents at regular intervals during the intervention; 3) a contest to increase motivation to be a nonsmoker; and 4) cessation assistance to adolescents who smoke.

Use of Incentives to Recruit Teens for Smoking Cessation, Brian Martinson, Ph.D., Principal Investigator

Little is known about effective strategies to recruit adolescent smokers to cessation programs. One approach that has not been applied in the adolescent population is the use of direct incentives. This study will assess the effectiveness of direct incentives to increase adolescent survey response rates, which is the first step for recruiting adolescents to the smoking prevention/cessation study described above.

Using the membership listing from a large managed

care organization, 4,000 adolescents will be randomly assigned to one of four recruitment conditions: 1) a prepaid cash incentive (\$2) enclosed with a survey; 2) a somewhat larger cash incentive (\$15), contingent on return of a completed survey; 3) entry into a drawing for one of 10 large cash prizes (\$200) upon return of a completed survey; or 4) no incentive.

The study will provide data on whether the use of incentives significantly improves the overall response rate, whether adolescent smokers respond in greater proportion depending on the type of incentive they receive, and whether the type of incentive affects smokers' willingness to be contacted by a health professional as part of the cessation intervention.

Adolescent Smoking Cessation in Dental Practices, Harry Lando, Ph.D., Principal Investigator

This study is a randomized controlled trial to evaluate the effectiveness of a dental clinic screening system to increase tobacco cessation among all adolescents aged 14 to 17 who report at least weekly smoking, and to prevent smoking among adolescents at risk of starting. The study compares a screening system alone and screening along with tailored motivational interviewing and telephone follow-up by a dental hygienist.

Adolescents will be drawn from dental clinics that are part of a large managed care organization and will be randomly assigned to intervention or comparison. Dental staff in all clinics will be trained in a systems approach to tobacco control. Using computerized dental appointment records, all adolescents with a scheduled appointment (n=6,400) will be screened for eligibility.

Eligible adolescents (853 smokers and 100 at-risk non-smokers) will complete a baseline telephone interview and may receive enhanced intervention at the time of their appointment. Trained dental hygienists will perform the motivational interviewing, conduct follow-up telephone calls, provide cessation materials, refer adolescents for nicotine replacement therapy, if applicable, and enlist parental support with the adolescent's permission.

These three studies should add significantly to our knowledge of effective smoking cessation and prevention strategies in the managed care setting. If the study outcomes are favorable, we will work to incorporate key intervention components into usual practice. MM

Harry Lando is a professor and DeAnn Lazovich is an assistant professor in the Division of Epidemiology, University of Minnesota School of Public Health.

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The Role of Epidemiology in the Court

Epidemiological studies can help establish causation in a product liability or negligence case.

Mark P. Friedlander Jr., LL.B.

Epidemiological studies are a valuable resource for physicians testifying in court that a product or an event led to a patient's illness. Much as physicians use data from epidemiological studies to determine the likely origin of a disease, attorneys also find a valuable ally in respected epidemiological studies when attempting to establish proof of causation in a product liability or negligence case.

Legal theories that support litigation for claims under product liability or negligence require the plaintiff's attorney to establish a theory of causation. The attorney must prove with a reasonable degree of medical certainty (greater than 50 percent chance) that the plaintiff's condition was caused by the product or offending action.

Consider, for example, a medical negligence case involving breast cancer alleging that misdiagnosis deprived the patient of the opportunity for a cure or effective palliation. The attorney will rely on clinical evidence to establish the stage or extent of the cancer at the time of the alleged misdiagnosis, and the plaintiff's medical expert will use epidemiological studies to show that the cure rate is higher when breast cancer is detected early.¹ The overwhelming epidemiological evidence relating lung cancer to smoking^{2,3} and exposure to asbestos^{4,5} have led to legions of lawsuits on behalf of victims.

In most cases, the plaintiff's attorney will use the medical opinion

and testimony of the treating physician or an independent specialist to show that the offending action or product caused the plaintiff's malady. However, when direct clinical information is not enough, an epidemiological study may become essential to the case. An epidemiological study can only demonstrate a statistical association and by itself is seldom enough; however, a statistical association that holds up by time, place, and person can provide strong support for causation.

Under the hearsay rule, treatises and scientific studies are not admissible evidence in most courts. For this reason, the medical expert must express his or her own opinion, even though the physician's opinion may, to some degree, be based on an epidemiological study.⁶ Thus, although the study may not be direct evidence, it is available to support and corroborate the medical witness's opinion. When an epidemiological study is critical to establishing causation, the attorney will often call an epidemiologist to testify as an expert medical witness.

An illustration of how epidemiological studies and epidemiologists' testimony played a key role in establishing causation is found in the thousands of cases and claims that arose in the late 1970s as a result of the ill-fated swine flu immunization program.

THE SWINE FLU VACCINATION CASE

Memories of this medical misadven-

ture recently resurfaced following incidents of the mysterious and deadly "avian" influenza virus in Hong Kong, which triggered alarms of a possible repeat of the 1918 flu pandemic that killed more than 20 million people around the world.

The same concern occurred two decades ago in 1976, when Martin Goldfield, M.D., chief epidemiologist for New Jersey, recognized a swine flu-type virus that had been cultured from an army recruit who died of influenza at Fort Dix. Public health officials feared that an influenza virus antigen shift might presage a pandemic similar to the 1918 catastrophe.

David Sencer, M.D., then head of the Centers for Disease Control, began a process that ultimately led to a National Influenza Immunization Program. From October to early December 1976, more than 40 million Americans received the swine flu vaccine. The program was suspended on December 16; although there were no reports of swine flu outbreaks, the incidence of Guillain-Barré syndrome (GBS) among those who had been vaccinated appeared to have increased.

Massive litigation followed. More than 5,000 claims were filed under the Federal Tort Claims Act. Of these claims, approximately 1,500 resulted in lawsuits. These were consolidated in multidistrict litigation.⁷

Although claims were filed for a variety of ailments, the primary focus was on GBS. Not a disease per se,

GBS involved a combination of clinical findings. Its onset was associated with a number of possible triggering events, including vaccinations, but no definitive cause was established.

After the abrupt termination of the vaccination program, the CDC asked epidemiologist Lawrence Schonberger, M.D., to prepare a study of the relationship between GBS and swine flu vaccinations.^{8,9} In his study, he examined the relative risk of contracting GBS from the swine flu inoculation as opposed to other possible causes. Schonberger found that 61.8 percent of the unvaccinated persons contracting GBS had had some acute illness within the four weeks before the onset of the first neurological symptoms. Only 32.8 percent of those who got GBS after receiving the swine flu shot had a history of an acute illness within the four weeks before GBS onset. He concluded that GBS was statistically more likely to have been from the inoculation if its onset began between the first and eighth week after the shot, and that the statistical likelihood that the vaccine caused GBS was 55 percent. This allowed a patient's treating physician to say with "reasonable medical certainty" that the swine flu vaccine caused the plaintiff to suffer GBS.

In several subsequent epidemiological studies, Leonard T. Kurland, M.D. (profiled on page 6), now professor emeritus of epidemiology at the Mayo Clinic, reexamined the data and reached a different conclusion.^{10,11} As Kurland pointed out, Schonberger had collected his data from diagnoses made by treating physicians, regardless of that physician's specialty, and without a neurologist reviewing the reporting symptoms or case histories.

Also, at that time there was no universally accepted test for diagnosing the syndrome, which was generally characterized by a subacute onset of progressive, predominantly motor neuropathy with a profound loss of reflexes; sometimes elevated spinal fluid protein with mononuclear leukocytes in the cerebrospinal fluid; and occasional involvement of the seventh cranial nerve. At the request of the National Institute of Neurological and Communicative

Disorders and Stroke (NINCDS), the American Neurological Association and the American Academy of Neurology established a uniform definition of GBS, but these standards were not applied in the Schonberger report. As a result, testifying physicians who relied on that study as a basis for their opinions were often challenged in court. In a number of swine flu trials, courtroom conflict involved epidemiologists' opposing opinions.

Often the only causal link between a disease and an event or a product is established by an epidemiological study. When a clinician relies on such a study, he or she often must support it with separate testimony from an epidemiologist to establish that the study followed accepted principles of epidemiology.

THE MORE RECENT FEN-PHEN CASE

In October 1997, a class action complaint was filed in federal court in California following an epidemiological study relating primary pulmonary hypertension, a rare but serious life-threatening lung disorder, with the popular weight loss drug fen-phen. Although the Food and Drug Administration had approved the use of phentermine in 1959, and fenfluramine in 1973, it had never approved their use in combination. In 1992, after published articles suggested that the tandem use of these drugs over time would help people lose weight, fen-phen was widely heralded. By mid-1996, however, reports of health risks began filtering in.

In 1997, clinical reports from the Mayo Clinic in Rochester, Minnesota, and MeritCare Medical Center in Fargo, North Dakota, revealed heart valve problems in patients taking fen-phen. New litigation will rely on epidemiologists and epidemiological studies to demonstrate the statistical association between these diseases and the use of fen-phen.¹²

CONCLUSION

When physicians testify as medical expert witnesses, either as treating physicians or independent specialists, they must express their opinions

with a reasonable degree of medical certainty. Although epidemiological studies can only demonstrate a statistical association between a disease and its likely cause, physician expert witnesses can use these studies as strong support and corroboration for their opinions. **MM**

Mark Friedlander Jr. is a civil trial attorney in Washington, D.C., and northern Virginia and served as liaison counsel in the swine flu multi-district litigation.

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MMA Alliance Works to Address Changes in 'Medical Life'

The MMA Alliance, a service organization for spouses of MMA members, has broadened its membership and activities to keep pace with societal changes.

Susan Maas

Rapid and far-reaching changes in health care mean new challenges for physicians and their families, says Minnesota Medical Association Alliance President Kendra Flanagan. With an ever-broadening membership—and an agenda that bears little resemblance to that of yesteryear's auxiliary—the Alliance is working to address those challenges.

The MMAA also is carrying on its 75-year tradition of public service with a wide array of initiatives. "This is truly a community service organization that just happens to be made up of physicians' spouses," Flanagan says.

Projects geared toward children, battered women, and flood-ravaged communities keep these committed activists busy. "We're not in the beauty parlor, getting our hair and nails done," Flanagan says with a laugh.

The MMAA is striving to ensure that the inside cover of every Minnesota phone directory lists a local domestic abuse crisis line. The Alliance has compiled a list of phone books that do not currently list domestic abuse crisis lines on the emergency page, along with names and numbers of local domestic violence intervention organizations, to send to US West for inclusion in future directories.

County alliances, under the direction of the MMAA, plan to "adopt" supervised visitation sites around the state, purchasing furniture, books, toys, and other needed

supplies for the children and parents who use them. Many of the sites, which serve as meeting places for

children and a parent who has lost custody, are unfurnished and bleak, says Flanagan.

County Alliances Serve Local Communities

At the county level, MMAA component alliances are involved in a range of projects to improve the quality of life in their communities.

Active alliances, including those in Blue Earth, Hennepin, Lake Superior, Mower, Ramsey, Stearns-Benton, and Zumbro Valley, take part in MMAA initiatives while pursuing their own local agendas.

Susan Meyer, president of the Lake Superior Medical Society Alliance, says her organization recently helped to furnish a new home for disenfranchised teenage girls in Duluth. The home is affiliated with Life House, a drop-in center for homeless youth, Meyer says. "They'll offer GED [courses], a computer, a library, and a nursery," she says. The LSMSA is outfitting the home's communal kitchen, purchasing a microwave, dishes, utensils, and other supplies.

The Stearns-Benton Medical Society Alliance had a "tremendously successful" holiday poinsettia and Norfolk pine sale this winter, says SBMSA president Jeanie Powell. Proceeds from the event benefit River Oaks Hospitality House, a home on the St. Cloud

Hospital campus that provides short-term affordable housing for out-of-towners receiving medical care in the area.

The SBMSA led the effort several years ago to renovate the house, which is owned by the hospital, and to make it available to visiting patients and their families. Since the house opened in October 1996, over 500 families from 15 states have used it. The flower sale that supports its operation has raised \$15,000 in three years, Powell says.

The Zumbro Valley Medical Society Alliance's recent and current projects include forming a speakers bureau and providing "personal care kits" with necessities like soap, shampoo, toothbrushes, and toothpaste, to a local women's shelter.

Harriet Hodgson, ZVMSA president, says the group also has implemented the AMA Alliance's SAVE program (Stop America's Violence Everywhere). Members have distributed conflict resolution tools and resources to public school students and teachers in the Rochester area.

With money of its own, as well as contributions from alliance groups in Pennsylvania and California, the MMAA hopes to donate hundreds of books to schools in the flood-devastated community of East Grand Forks, Minnesota. By mid-March the Alliance had raised over \$1,200 for the project, and Alliance members are talking to a number of publishing companies about donating books and matching funds to the effort, Flanagan says.

A major focus of the Alliance is the growing pressures on physicians working under managed care. Dramatic changes in the health care climate affect physicians and their families, Flanagan says.

This year, for the first time, the MMA and the Alliance will meet jointly at the MMA Annual Meeting in October. The Alliance plans to host a discussion on coping with stress and a workshop on retirement. "How do you address the issue of a spouse who's been working 12 hours a day for 30 or 40 years and hasn't had time for any hobbies or outside interests? These are the kind of situational problems that occur in medical families," Flanagan explains.

The composition of the Alliance has changed over time and now includes women—and men—who work in a wide range of professions, including accountants, attorneys, homemakers, and even physicians. The challenge, Flanagan says, is "how to make the Alliance credible and attractive to more two-professional families."

Alliance members are looking at ways of making the group more inclusive, perhaps by creating a new designation, such as Friend of the Alliance, to foster participation from people who are not spouses of physicians. Physicians' adult children, same-sex companions, longtime partners, and others close to the practice of medicine would be invited, says Flanagan. Although such a designation would not be recognized on a national level—the AMA Alliance only admits physicians' spouses as members—a Friend of the Alliance could participate locally and at the state level.

The Alliance hosted the first-ever

North Central Regional Conference in March. Alliance organizations from 11 other state medical societies—Illinois, Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin—participated in the two-day conference. It was timed to coincide with a March 5 seminar on coping titled "Patchwork: Putting the Pieces Together," sponsored by Mayo Medical Center, the Zumbro Valley Medical Alliance, and the Mayo Foundation for Medical Education & Research. MM

Susan Maas is a writer in the Minnesota Medical Association's Communications Department.

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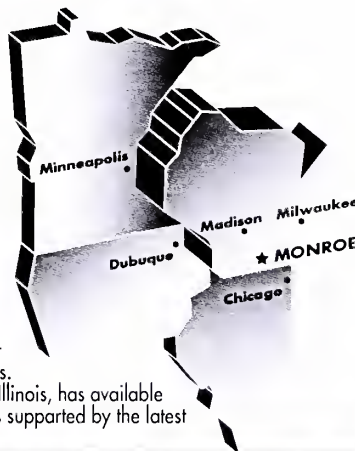
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People and Places Making Medical News

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New Chair Named for 'U' Pediatric Heart Research

John Foker, M.D., Ph.D., professor of surgery and pediatrics, has been named the first academic pediatric cardiothoracic surgical science chair at the University of Minnesota Medical School. The \$3 million endowment will permanently support the university's research in unexplored techniques and treatment possibilities in pediatric cardiothoracic surgery.

Foker, a pediatric cardiothoracic surgeon, has contributed to the field in the surgical correction of rare birth defects in children. For example, he designed a method of surgical repair that stimulates the growth of either of the heart's two pumping chambers in children born with a chamber that is too small. The procedure saves these children from a life of operations, medications, and ultimately heart transplantation. He also invented a technique by which he connects the ends of an undeveloped esophagus in children born without one, giving them the ability to swallow and eat normally.

Foker received an M.D. from Harvard Medical School in 1963 and a doctorate in microbiology from the University of Minnesota in 1969.

Kersey Elected Transplantation Society President

John Kersey, M.D., director of the University of Minnesota Cancer Center, has been elected president of the American Society for Blood and Marrow Transplantation. Kersey is one of a team of physicians who developed the university's blood and marrow transplant program. A professor of laboratory medicine and pathology, pediatrics,

and therapeutic radiology, Kersey received a bachelor's degree from Dartmouth College and a medical degree from the University of Minnesota.

The American Society for Blood and Marrow Transplantation is a national organization of more than 800 members established to promote education, research, and medical development of blood and marrow transplantation.

New Team to Head Fairview-University Medical Center

Fairview has named a new executive team to lead Fairview-University Medical Center in Minneapolis for the second phase of the merger between Fairview and the University Hospital and Clinic. **Gordon Alexander, M.D.**, is senior vice president and administrator/chief executive officer and **Pam Tibbetts** is senior vice president and chief operating officer. Alexander will continue to be chief medical officer of the Fairview system.

They succeed **Peter Rapp** and **Don Berglund**, who were Fairview-University administrator/chief executive officer and chief operating officer, respectively. The two remain system senior vice presidents. Rapp now heads regional care systems and continuum operations, focusing on integrating research and education throughout Fairview and building an outreach program. Berglund heads clinical integration and will continue to build a medical team of community and university physicians.

Alexander, the first physician hospital CEO in the Fairview system, has 14 years of private practice experience and close ties to the university's Academic Health Center. He has been a Fairview system senior vice president for five years. Tibbetts joined Fairview 18 years ago and most recently was system senior vice president of clinical integration.

Fairview Selects Northland VP

Fairview has selected **Jeanne M. Lally** as senior vice president and administrator for Fairview Northland Regional Health Care, which includes Fairview Northland Regional Hospital in Princeton and primary care clinics in five locations. She has been president of Fairview's continuum services since 1991.

HCMC Physician Awarded for Work in Sleep Disorders

Mark W. Mahowald, M.D., medical director of the Minnesota Regional Sleep Disorders Center at Hennepin County Medical Center, has been named the 1998 recipient of the American Sleep Disorders Association Nathaniel Kleitman Distinguished Service Award for his work in the field of sleep research and sleep disorders medicine. He will receive the award in New Orleans at the June 20 meeting of the Association of Professional Sleep Societies.

Children's Hospitals and Clinics Elect Staff and Board Members

The professional staff of Children's Hospitals and Clinics has elected **R. Hampton Rich, M.D.**, as chief of staff. He will also serve on the organization's board of directors. A physician with Pediatric Surgical Associates, Rich has practiced at Children's since 1982 and was previously chief of surgery. The professional staff has also elected **John R. Balfanz, M.D.**, vice chief of staff. He joined Children's in St. Paul in 1975. **Thomas Hellmich, M.D.**, was elected secretary-treasurer. He is an emergency services doctor at Children's in St. Paul.

The board of directors for Children's Hospitals and Clinics has elected new officers and appointed three new board mem-

bers. The officers are Kevin Roberg, chair; Norbert Conzemius, vice chair; Susan Mahle, M.D., secretary; and John Murphy, treasurer. The three new board members, appointed for three-year terms, are Mark A. Cohn, chair and chief executive officer of Damark International; B. Kristine Johnson, senior vice president and chief administrative officer of Medtronic; and Billy Weisman, president of Weisman Enterprises.

Places

Blue Cross Planning Hospital in Fargo

Blue Cross and Blue Shield of Minnesota together with Fargo-based Dakota Clinic is planning to build a new \$50 million inpatient and outpatient facility, set to open in 2000. It would be the first hospital owned by BCBSM.

BCBSM has a strong relationship with Dakota Clinic; they have a 20-year agreement under which BCBSM will invest \$27 million in the clinic while the clinic remains independent.

Dakota Clinic doctors typically refer patients to Dakota Heartland, which is run by a Dakota Clinic physicians' foundation and a for-profit hospital administrator, Houston-based Paracelsus Healthcare Corp. In a *CityBusiness* article, spokespeople from Dakota Heartland and MeritCare, both hospitals in the Fargo/Moorhead area, expressed doubt that the region's demographics would support a third hospital. Carrie Johnson of MeritCare said the market already has about 3.5 beds per 1,000 residents, about 2 beds more per 1,000 residents than needed.

Blue Cross spokespeople responded that regardless of bed numbers, Fargo will benefit from the new facility, which will be designed to mesh inpatient and outpatient care.

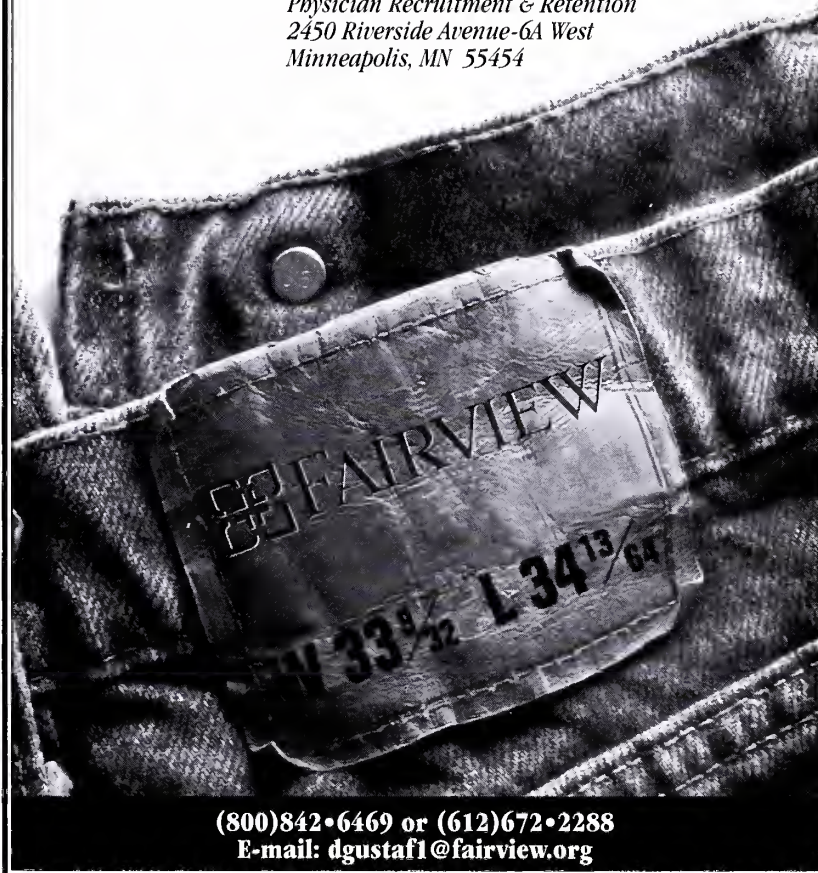
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Fairview Opens Facial Paralysis Clinic

Fairview Rehabilitation Services has opened a Facial Paralysis Clinic at the Fairview-University Medical Center, Riverside campus, in

Minneapolis. Physical therapists and speech-language pathologists provide rehabilitation that includes neuromuscular retraining, a therapy to improve facial motor control. The clinic serves people affected by such problems as



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Socioeconomics

Medica Starting New Plan that Uses 'Care Systems'

Medica has developed a new health plan product that resembles the Buyers Health Care Action Group's plan. BHCAG contracts directly with "care systems," groups of clinics, hospitals, and specialists that have organized to offer care as one group and are held accountable for how they manage patient care and costs. BHCAG employers pay each care system a set fee for each service it performs.

Medica has talked to a number of the groups working with BHCAG about offering a similar product through Medica. Medica would pay the care systems on a capitated basis.

Employers and consumers who choose the new Medica plan over Medica Choice would pay a lower premium but would have less choice in physicians and hospitals. The product will be available in 1999.

Andersen Corp. Joins BHCAG

Andersen Corp. announced in April that it has joined the Buyers Health Care Action Group (BHCAG), bringing the health care coalition membership up to 30 large employers. Andersen will join US West and the Minnesota Department of Employee Relations as an associate member, meaning the company will help the coalition with lobbying, but it will not offer its employees Choice Plus, the health care program BHCAG created and manages. The company said it may make Choice Plus available in the near future.

Minnesota Eye Consultants Acquires First Eye Care Center

Minneapolis-based Minnesota Eye Consultants, Inc., has acquired First Eye Care Center, Inc., of

Bloomington, located at 91st and Lyndale. Minnesota Eye Consultants, under the direction of Richard Lindstrom, M.D., Thomas Samuelson, M.D., David Hardten, M.D., and Ralph Chu, M.D., is located at the Phillips Eye Institute.

HMO Profitability Declines

The most dramatic HMO financial trend for the years 1994 through third quarter 1997 is a decline in profitability, according to the second annual "HMO Financial Benchmarks" report published by InterStudy Publications.

In 1994, nearly 90 percent of all HMOs were profitable, with an average margin of 2.4 percent. Industry profitability has steadily declined through third quarter 1997, when only 49 percent of plans were profitable, with an average margin of -1.2 percent.

One reason for the trend is purchasers' success in securing low premium increases. The typical HMO's premiums rose about 5 percent in 1994; by 1996, the average premium increase was only 0.5 percent. Another reason is medical expense inflation. Although HMO use is associated with declining medical cost inflation, health plans have not controlled costs as well as purchasers have controlled premiums. In 1994, medical costs increased 5 percent, declining to 3 percent in 1996. The study reported evidence that health plans are learning to better control medical costs so they can avoid large premium increases.

Stings Show Roseville Retailers Sell Alcohol to Minors

More than half of the liquor retailers in Roseville, Minnesota, sold or served alcohol to underage decoys in the city's first alcohol compliance checks, despite advance warning from the Roseville Police Department. Most of the 22 establishments that served the minors did not ask for identification from the 17- and 20-year-old decoys. Sixteen businesses passed

the checks. The retailers checked included liquor stores, bars, a supermarket, clubs, and restaurants.

Roseville is one of nine Minnesota communities using grants from the Minnesota Join Together Coalition to Reduce Underage Drinking to finance alcohol compliance checks.

Rates, Trends, Data

About One in Five Minneapolis Preteens Have Smoked

In an Allina survey of 1,347 Minneapolis students in grades four through eight, 18.7 percent of the students said they have smoked. On average, the students started smoking at age 10.

"What I find surprising is that one-third of them said they found it easy to get cigarettes from vending machines, and that 70 percent said that it was not hard to get hold of a cigarette," said Rob Jeddeloh, M.D., medical director of Allina's Care System Innovation, a division of Allina Health Plan, in a *Saint Paul Pioneer Press* article.

Allina will use the survey as baseline data for its Project ACT, a smoking prevention program that works with Minneapolis elementary schools. As part of the project, teachers use a special smoking cessation curriculum.

Law & Policy

Medica, HealthPartners Suing Tobacco Industry

Following the lead of Blue Cross and Blue Shield of Minnesota and the state attorney general's office, Minnesota's two largest managed care organizations, Medica and HealthPartners, have filed a lawsuit against the tobacco industry for alleged consumer fraud and antitrust practices. The suit seeks to recover health care costs related to tobacco use.

The case brought by Blue Cross and the state has led to the release of thousands of previously secret

tobacco industry documents. "The revelation of the additional documents, which apparently show that the tobacco industry targeted children and teenagers as tomorrow's smokers, strengthens our resolve to hold the industry accountable for their fraud and deceit," wrote Andrea Walsh, HealthPartners senior vice president of public affairs, in a press statement.

Medical Research

Tamoxifen Reduces Breast Cancer Risk But Increases Other Risks

The drug tamoxifen offers protection to women at high risk of developing breast cancer but increases their risk of uterine cancer and pulmonary embolism, according to results from the national Breast Cancer Prevention Trial, funded by the National Institutes of Health.

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Among women at high risk for breast cancer, tamoxifen reduced the chance of developing the disease by 45 percent when compared with a control group taking a placebo.

Women taking the drug had a 2 percent to 3 percent chance of developing uterine cancer, compared with 1 percent in the control group. However, researchers pointed out that both uterine cancer and pulmonary embolism are rarer than breast cancer in women at high risk for the disease.

The results are being analyzed at the Pittsburgh-based National Surgical Adjuvant Breast and Bowel Project. The analysis, expected to be completed by June at the latest, should help researchers develop a formula for doctors to determine in which cases the drug's anticancer benefit outweighs its tendency to increase the risk of

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uterine cancer and the risk of potentially lethal blood clots in the lungs, said P.J. Flynn, M.D., a Minneapolis cancer researcher who supervised tamoxifen trials at 12 Twin Cities hospitals and several dozen clinics.

The six-year study was halted in April—a year early—when the benefit of tamoxifen became obvious to scientists and officials.

Researchers: Food Stamp Cuts Lead to Hunger, Poor Health

Researchers at Hennepin County Medical Center (HCMC) in Minneapolis and the University of Minnesota have found links between recent reductions in food stamp allowances, hunger, and poor health.

In the study, reported in the April 15 *Journal of the American Medical Association*, the research team interviewed 567 patients at HCMC. Twelve percent said they did not have enough food, and 13 percent reported not eating for an

entire day because they could not afford food. About half of the 222 patients who were receiving food stamps in the previous year had had their benefits reduced or eliminated. These patients were more likely to report hunger and food insecurities than those whose benefits had not changed, report the authors, Karin Nelson, M.D., a third-year internal medicine resident at HCMC; internist Nicole Lurie, M.D., professor of medicine and public health; and Margaret Brown, a graduate student in the university's Institute for Health Services Research.

The authors also surveyed 170 diabetics who were filling their insulin prescriptions at the HCMC pharmacy. Of the 103 who reported insulin reactions, 32 said it was because they could not afford food.

Human Trials to Begin on 'U' Artificial Liver Machine

University of Minnesota researchers are tentatively set to begin human trials in September on a new artificial liver machine. They hope the machine will allow time for some damaged livers to heal so the patients will not need a transplant. For other patients, the machine will buy time while they wait for a transplant. University researchers began developing the machine, an external device similar to a kidney dialysis machine, in 1988.

The trials will begin with 15 extremely ill patients suffering from fulminant viral hepatitis. The researchers said they expect the FDA will approve the machine for wider use within four years.

In the meantime, the University of Minnesota has licensed the patented system to Algenix Inc., an Arden Hills company created specifically to finance and carry out the project. The company's chief executive officer, Leonard Ruiz, a chemist who has headed several biotechnology ventures, has started looking for local investors; the company needs to raise about \$1.5 million initially and another \$5 million later on to finance the company.

Better Standards Needed for High School Athletic Exams

A national standard for screening high school athletes for dangerous cardiovascular defects is needed, according to Minneapolis cardiologist Barry Maron, M.D., director of cardiovascular research at the Minneapolis Heart Institute Foundation.

Maron and a colleague from Kansas City, Missouri, conducted a detailed analysis of the cardiovascular portions of high school athlete screening programs in all 50 states and the District of Columbia. Their findings, reported at the American College of Cardiology's annual meeting, ranked Missouri's screening program at the top; Minnesota's came out in the middle, but not far below the states with the best programs. Wisconsin came out at the bottom.

Maron said another problem with monitoring athletic health risks is that there is no national system to track the number of student athletes who die suddenly from undetected cardiovascular defects. Three Minnesota high school athletes have died of sudden cardiac arrest in the past 10 years, said Maron, a rate of one in 200,000. But there are no national figures with which to compare that number.

Maron's study found a wide range in the thoroughness of state's forms for conducting athletic exams. For example, while some states have detailed guidelines, Wisconsin and Pennsylvania have no official form to guide physicians. (Minnesota physicians follow a comprehensive guide of more than 50 questions, some of which are designed to identify risk for cardiovascular disease.) However, no one knows how well doctors follow the guidelines. In addition, some states allow a nurse practitioner, physician's assistant, or chiropractor to conduct the exams.

Maron suggested that the National Federation of High Schools in Kansas City implement a standard form. **MM**

CANCER

continued from page 46

radiotherapy to the primary tumor, hilar, and mediastinal nodes simultaneous with cycle 2 or 3. Treatments based on this approach reduce local recurrence and yield medial survivals of 18 to 24 months.

Non-small cell lung cancer may be cured in over 50% of patients treated with lobectomy for stage I disease.¹⁰ Stage II disease may also be surgically resectable but has a high recurrence rate and only a 25% five-year survival rate. The vast majority of patients with stage III disease have regionally advanced unresectable disease and are treated with high-dose radiotherapy. Their survival is improved if this is preceded by neoadjuvant chemotherapy. Stage IV disease is treated with chemotherapy, while radiotherapy is reserved for a palliative role.

CONCLUSION

There are a few things primary care physicians can do to reduce both the

incidence and mortality of breast, prostate, colorectal, and lung cancers. These include:

- encourage smokers to quit and nonsmokers to abstain;
- promote diets lower in fat and higher in fruits and vegetables;
- encourage all women aged 50 and over to have annual mammography and clinical examinations and counsel women aged 44 to 49 on the risks and benefits of screening;
- encourage men and women age 50 and over to undergo annual fecal occult blood testing (possibly with five-year flexible sigmoidoscopy);
- obtain a family history of colorectal cancer and recommend colonoscopy screening for high-risk patients.

MM

Jack Mandel is professor and head, Mayo Chair in Public Health, in the Division of Environmental and Occupational Health, School of Public Health, at the University of Minnesota. Martin Oken is director of the Virginia Piper Cancer Institute at Abbott Northwestern Hospital in Minneapolis.

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MAY 1998

May 8 **Emerging Infections in Clinical Practice** University of Minnesota; Minneapolis Airport Marriott, Bloomington, MN. CONTACT: Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 13 **Principles of Diabetes Management: Basics & Trends** United Hospital Diabetes Center; United Hospital, St. Paul, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 15 **Medical Management of the Surgical Patient** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 15-16 **John I. Coe Symposium and Minnesota Society of Pathologists Meeting** Hennepin County Medical Center; Radisson Hotel South, Bloomington, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 15 & May 22 **Advanced Cardiac Life Support (ACLS)** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 19-21 **Hepatitis Coordinators Meeting** University of Minnesota/Continuing Medical Education; Marriott at Capitol, Austin, TX. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 20-22 **28th Annual Meeting: Current Concepts in Radiation Therapy** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

May 5 **Natural Rubber/Latex Allergy: Recognition, Treatment, and Prevention (Video Conference)** American Medical Association; Vance DeMong Auditorium, North Memorial Health Care, Robbinsdale, MN. CONTACT: Lisa Miller, Medical Alley, 1550 Utica Avenue S., St. Louis Park, MN 55416; 612/542-3077.

May 8 **Emerging Infections in Clinical Practice** University of Minnesota; Minneapolis Airport Marriott, Bloomington, MN. CONTACT: Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 19-21 **Hepatitis Coordinators Meeting** University of Minnesota/Continuing Medical Education; Marriott at Capitol, Austin, TX. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 29-30 **The Prescription: A Latex Safe Environment—'Stop the Sensitization'** Allina Health System; The Northland Inn, Brooklyn Park, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

June 23 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Julie Page, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 21 **Advanced Diabetes Management: Complications & Trends** United Hospital Diabetes Center; United Hospital, St. Paul, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 22 **Poisonous Mushrooms** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

May 29 **Interventional Radiology** Consulting Radiologists, Ltd.; Hotel Sofitel, Bloomington, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 29-30 **The Prescription: A Latex Safe Environment—'Stop the Sensitization'** Allina Health System; The Northland Inn, Brooklyn Park, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

May 29-31 **10th Annual North Central Neonatology Issues Conference** University of Minnesota/Continuing Medical Education; The Osthoff, Elkhart Lake, WI. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 30 **Critical Care: A Team Approach** Mayo Foundation; Mayo Clinic, Phillips Hall, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

J U N E 1 9 9 8

June 4-6 **Fifth Annual Mayo Interventional Cardiology Symposium** Mayo Foundation; Leighton Auditorium, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 4-6 **Workshops in Clinical Hypnosis** University of Minnesota/Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 5-6 **Annual Spring Sports Medicine Conference** University of Minnesota, Minneapolis Sports Medicine Center; Holiday Inn Metrodome, Minneapolis, MN. CONTACT: Bob Finke, 701 25th Avenue S, Suite 150, Minneapolis, MN 55454; 612/672-4800.

June 12 **Treatment of Addictive Disorders** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Regis-

trar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13 **New Options for Erectile Dysfunction** University of Minnesota/Continuing Medical Education; Bloomington Marriot, Bloomington, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13 **Prostate Microwave Training Course** Abbott Northwestern Hospital Insitiute for Minimally Invasive Technologies; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

June 17-19 **Topics and Advances in Pediatrics** University of Minnesota/Continuing Medical Education; Radison Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 17-20 **62nd Annual Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota Medical School Department of Surgery; Willey Hall, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 800/776-8636.

June 23 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

June 25-27 **First Annual Meeting International Society for Minimally Invasive Cardiac Surgery** Minneapolis Heart Institute Foundation; Marriott Hotel-City Center, Minneapolis, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

J U L Y 1 9 9 8

July 16-18 **Management Strategies in Hematologic Oncology** Mayo Medical Laboratories; Ihilani Resort and Spa, Kapolei, Oahu, HI. CONTACT: Kathy Bates, 200 First Street SW, Rochester, MN 55905; 507/284-3942.

July 17-19 **Fifth Annual Course on Lasers in Cutaneous and Cosmetic Surgery** University of Minnesota/Continuing Medical Education, Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 800/776-8636.

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- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
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Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: occupational medicine, dermatology, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

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and are planning on expanding in 1998. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (1/98-R)

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MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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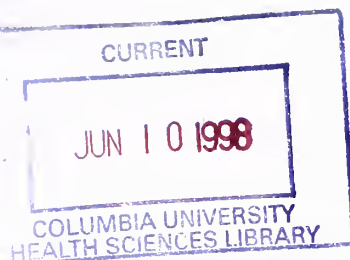
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Batten Down the Hatches

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format will result in nonpayment and may trigger audits, fines, and penalties. Ready to sign up?

Although this may sound like a page from a Mafia protection contract, it is a fairly accurate description of Medicare. Since its inception in 1966, Medicare has had a stormy existence. Utilization review, DRGs, and HMO risk contracts—all attempts to stem the red tide of debt—weathered caustic critiques. The temperature got hotter when Hillary attempted to launch the Clinton health plan. Now the dew point has become unbearable for many doctors with the introduction of the evaluation and management (E&M) coding guidelines and the accompanying fraud and abuse provisions. High dew points mean thunderheads, and the rumble is growing.

The E&M codes were released in 1997 to “refine” the 1994 RBRVS system. Although the original RBRVS defined E&M codes in some detail, the documentation required to “qualify” for a given code was primarily left to physician judgment. Spurred by estimated yearly Medicare losses to fraud and abuse of \$21 billion, HCFA spelled out what had to be included in physician documentation in a “brief” 45-page document, the intricacies of which would bring a smirk to the Minotaur. Failure to navigate this

maze could bring on the fraud squad, empowered to audit providers rationally or randomly to uncover that \$21 billion (see this month's Commentary, page 46, and Medicine Law & Policy, page 49).

Why is the E&M storm so tempestuous? Certainly, money matters. Physicians who limit fee increases to cover rises in cost of living then watch Medicare payments stall or fall are bound to dislike such a stingy payer instituting a system that consumes physician and staff time.

Certainly, red tape matters. The tangle of Medicare paperwork has led to colorful descriptors like “hassle factor” and a deluge of rejected “medically unnecessary” claims. Now E&M code regulations ask practicing physicians to document visits like third-year medical students and then be “graded” by audits that count their right answers. Most physicians want to do a competent job of evaluating patients and documenting their evaluation. But practice is a balance between completeness and time, and the absurd requirements of the E&M guidelines erode time with the patient.

Probably what matters most is the presumption of guilt. Most physicians consider themselves to be law-abiding. When we read about million-dollar fraud settlements with large companies like Caremark, we say, “That's not me.” So when HCFA says they're out to find \$21 billion of fraud and abuse and doctors are under investigation, we say, “When did we become crooks?” HCFA insists that only “patterns of abuse” will be prosecuted, but anybody's number can come up in a random audit, and the “educational” experience would be painful and expensive.

The debris from the E&M storm prompted a recent “fly-in” conference at the AMA. HCFA responded by postponing implementation of the E&M codes indefinitely. So, for now, the debate over how we will change our practices to comply is deferred. But future Medicare gales will cloud physicians' days. Until we find a way to stem the red tide of Medicare deficits, we'd better keep the storm gear handy.

—Charles R. Meyer, M.D., Editor-in-Chief



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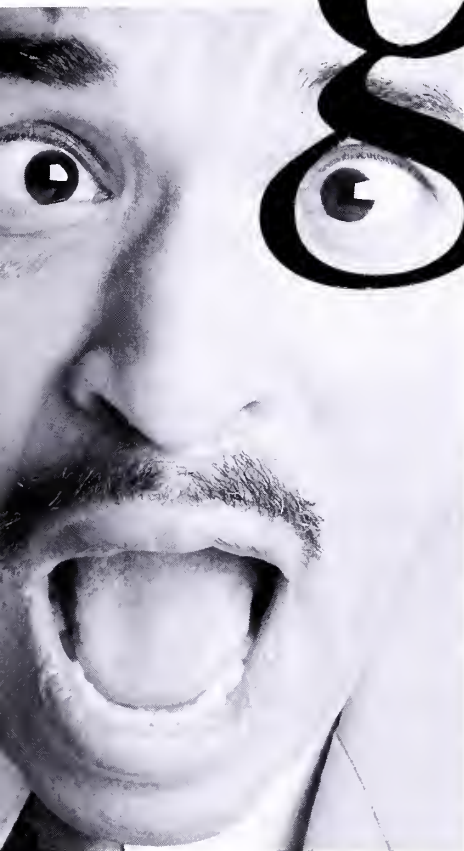
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Urban Medicine: Beyond the Stereotype

As I read the April *Minnesota Medicine*, with its useful and timely articles on refugee screening; adolescents in gangs; lead poisoning; care for the urban poor at the Glenwood-Lyndale Community Clinic, La Clinica, and the Union Gospel Mission, I felt a vague sense of unease, of something wrong. Accompanying photos showed a smiling young African-American pediatrician framed by the Minneapolis skyline, a white primary care doctor riding his bicycle to work in the winter, a tired looking emergency medicine specialist at 1:09 a.m.

My discomfort with these images took shape after I read the editorial about the saintly nature of these caregivers: Do all poor people live in the inner city, and does care for them occur only in certain places, provided by people who've devoted their lives to this? It all seems so neatly divided, so predictable, but somehow so out of date.

What about me? I've seen mostly private patients in 23 years of practice, but like many Minnesota physicians, I see uninsured patients mixed in with the others (and from time to time "forget" to charge them or "downcode" a charge). Also, it seems that I'm seeing more Medicaid, General Assistance, and MinnesotaCare patients now that these programs tend to be administered through private insurance companies.

What about the private hospital where I work, Abbott Northwestern? The emergency department is filled with inner-city patients; about 85 percent of the patients

seen on an average day come from the surrounding Phillips neighborhood. A recent seven-month survey of African immigrants and refugees seen in one of our hospital's clinics turned up more than 100 patients newly arrived from Somalia, Ethiopia, Liberia, Nigeria, Togo, Cameroon, Kenya, Zaire, Egypt, Libya, Rwanda, and Sierra Leone. Few spoke English. Nine percent had active tuberculosis; one patient had malaria.

The world today is a different place than it is in our memories. Clinics and hospitals funded by the government or charity are no longer the only options for poor

people; a large amount of their care is provided in the private sector. People from other states and around the world are showing up in emergency departments in the Twin Cities and across Minnesota. All doctors need to be prepared to care for the many problems associated with urban poverty and immigration. I wish your April issue had relied less on stereotypes in making this important point.

Richard Adair, M.D.
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Where's the Helmet?

I enjoyed reading in your April issue about Hennepin County Medical Center and the important work they are doing. The article "HCMC Reaches Out from the Inner City" describes how important Dr. Lowell Stoltzfus is to the HCMC program at Glenwood-Lyndale Community Clinic. Because he is a role model to his patients and others in the neighborhood, I would strongly urge him to wear a bicycle helmet as he commutes to work on his bike. We lost a colleague at my clinic last summer following a bike/truck accident. Because of him, we have redoubled our efforts to promote the use of bike helmets among physicians and patients alike.

Mary Meland, M.D.
HealthPartners Bloomington Clinic
Bloomington, Minnesota

Successful Hospitalist Program in Duluth

I read your article on hospitalists in the March issue ("The Hospitalist Trend: A Work in Progress"). Our office has the only hospitalist program in Duluth to date. After over a year of discussion and planning, we started our program last October. The physicians see their own inpatients during rounds, but our hospitalist takes over from there. In our service, each physician spends a week as the hospitalist, taking the week after their weekend on call.

We've discovered three significant benefits of this service so far: 1) We have been able to increase patient hours for physicians in the office; 2) physician satisfaction has increased, both at the clinic, because the physicians don't have

to go back to the hospital for admissions, consults, or to see patients who are unstable, and at the hospital, because the hospitalist can spend more time working up patients instead of returning to the office to start clinic; and 3) the hospital units and referring physicians have ready access to our hospitalists when necessary.

In addition, inpatient referrals from out-of-town clinics have increased because we are able to see patients as soon as they're

admitted and let the primary doc know their status right away.

At first we were wondering if we could keep a physician busy all day at the hospital; now, some days we could use a second hospitalist!

Cathy VonRueden
Clinic Administrator
Duluth Internal Medicine Associates
Duluth, Minnesota



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GO^{The}-BETWEEN

By Julie Ahasay

If Hollywood were casting a film about a small-town doctor, Dan Benzie, M.D., could be the star. In his canvas barn coat, billed cap, flannel shirt, and jeans, he already has the wardrobe.

But he wouldn't have the time. He's a family doctor, a citizen of a small town, an academic, a hockey booster, and a diplomat. All these roles came into play two years ago when Benzie was put in charge of finding rural communities willing to help train the next generation of family practice physicians.

With a well-worn work boot planted firmly in two worlds—academia and rural medical practice—he was the right man to design the community training sites for the University of Minnesota–Duluth School of Medicine's Rural Health School (RHS), which is bringing medical, nursing, physician assistant, and pharmacy students to rural communities to learn about providing rural health care as a team (see related article, page 27). So far, the communities of Moose Lake, Willmar, Itaska County, New Ulm, and Staples are participating.

Benzie was the obvious choice to chair the RHS community development committee, according to Byron Crouse, M.D., director of the Rural Health School and UMD's Department of Family Practice. "Dan is a unique individual who really has that community-rooted commitment," Crouse says. "He is truly a rural practitioner. He understands and lives community-oriented medicine. He also happens to have the gift of being an excellent role model and teacher."

As a teacher and role model, Benzie has served on UMD's clinical faculty as director of third- and fourth-year rotations and as a preceptor. Now he's added his role with the Rural Health School.

Benzie likes to expose students to the uniqueness of rural medicine.

"Rural comes right to the surface," he says. It comes naturally and out of necessity. You see your patients in the office and then see them again that night at the ball game or the IGA. You feel part of their lives. We would like that to happen everywhere, but it doesn't always occur in a bigger city."

In addition to his ongoing duties as liaison between UMD and the communities participating in RHS, Benzie is president and medical director of Gateway Family Health Clinic in Moose Lake and Sandstone. He continues as a preceptor and travels to Duluth from his home in Sturgeon Lake every Thursday to meet with colleagues and students.

Benzie, who grew up in Grand Rapids, Minnesota, graduated from the University of Minnesota Medical School and completed his residency with the Duluth Family Practice Center. From the beginning, Benzie says, he was drawn to a rural practice for one distinct reason: family. His inclusive definition takes into account his wife, Sue, and children, Jason (24) and James (22), as well as the larger community. "Here, there is a family of patients as well," he says. "You have a life with your patients. You volunteer and do things because you feel part of the community. As family doctors, before we focus on the sore foot, cough, or pain, we focus on a patient as a person with a distinct place in the community. We get to know them individually."

That sense of belonging is something Benzie emphasizes to his students. "We try to instill in them a sense of community responsibility and the importance of their assimilating into that community."

Benzie sets a high standard for community involvement. He spent five years as president of the Amateur Hockey Association in Moose Lake, eight years as continuing education

*Dan Benzie, M.D.,
serves as liaison
between two very
different worlds—
the UMD School of
Medicine and rural
communities hosting
the next generation
of doctors.*

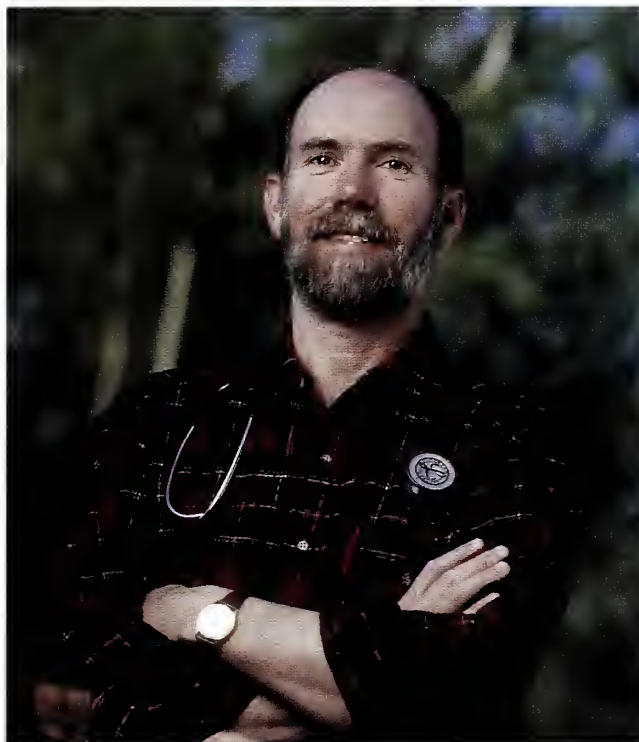
director of Mercy Hospital, he chaired the Moose Lake Sanitation and Sewer District from 1990 to 1993, and he led the organization that developed a youth soccer program in the town.

His respect for his neighbors is something he tries to pass along to students. Benzie tells students that while they do very important work, they're just like anybody else. "We need to remember that what everyone else does is special, too. The farmer who works long hours in the field and the teachers who work with children, they are just as important as we are."

Benzie's years of medical practice in a rural setting taught him the importance of an interdisciplinary, community approach to health care. When Benzie approached the formidable task of finding community sites for the RHS, he focused first on building the right team to help him. He involved community representatives from around the state, including public health workers, nurses, health plan representatives, pharmacists, and physician assistants. In the end, only one doctor besides Benzie was a member of the committee.

There was homework to do. "We pulled out maps and looked at other programs," Benzie says. "Where possible, we tried to bring this resource to communities that already had some experience with students in their medical facilities. We needed communities that were comfortable with the idea of taking on students. Then you already have patients who feel like they're helping to train the next generation."

According to Crouse, the RHS also searched for communities that were willing to change their view of medical practice. The students work with pharmacists, physician assistants, nurse practitioners, physical therapists, occupational therapists, and social service professionals. "We teach our students an interdisciplinary approach. The sites for this program needed to reinforce that," Crouse says. Another challenge was finding physicians willing to make the commitment to teach on-site. "I had to do a lot of arm-twisting," Benzie laughs. "This is a huge responsibility. But almost everyone says yes.



PHOTOGRAPH BY JEFF FREY

Doctors like to please people."

Crouse credits Benzie's listening skills for the program's success: "In the past, an academic unit would develop a curriculum, then go to the sites and say, 'Do it.' Dan asked them, 'What do you need? What have the students been lacking?' Then we worked on the curriculum. Dan has the vision and the ability to articulate for both sides."

Benzie's work was not over once the sites were established. He continues to serve as liaison between the medical school and the communities. "I try to fill that role," he says. "I'm sure university people get tired of hearing the word 'community' from me.

It's hard for us in academic environments to recognize that if we want to succeed at this kind of program, we have to go to the community. We can't expect them to always come to us. There are geographic realities. And there are the realities of a rural family practice."

That can mean 7 a.m. meetings in small towns miles away from campus. It also means providing ongoing training for participating physicians. In true Benzie style, that training goes in both directions. Community practitioners and university faculty come together at retreats throughout the year to share information and insights. The focus is half academic, half practice. "We blend and learn from each other," Benzie says.

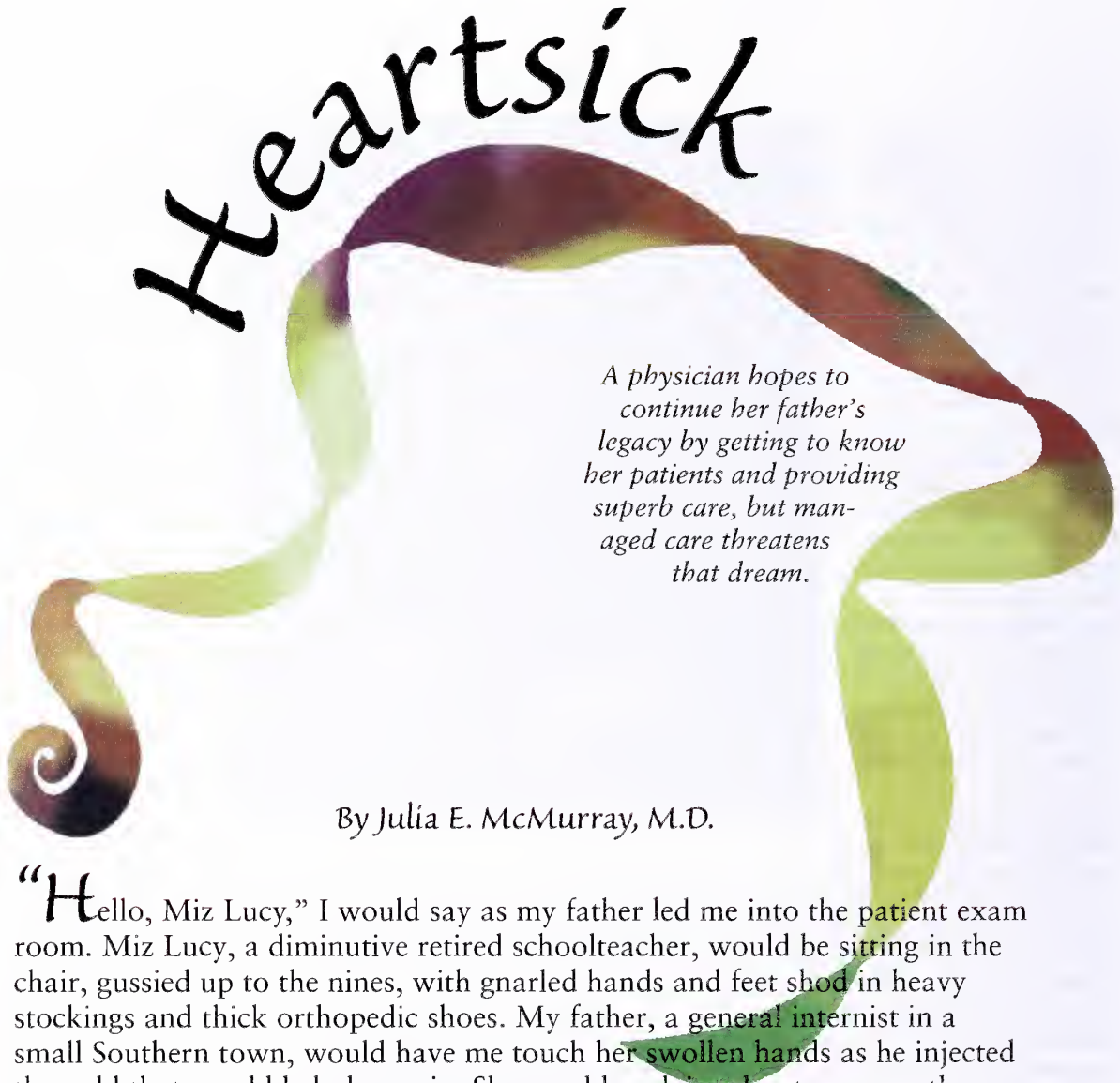
He also publishes a newsletter filled with practical teaching tips and advice for community teachers throughout the state. Respect for both physician and student is evident. In the January 1997 issue, Benzie writes: "Listen to what the students would like to learn in the rotation, combine this with what you feel would be important for them to know or learn and come to a mutual agreement on the goals of the rotation."

When he's choosing a community site, Benzie says he looks for "people who understand what it means to be a role model." He rarely misses the mark. As the old adage says, "It takes one to know one."

MM

Julie Abasay is a free-lance writer living in Duluth.

Heartsick



*A physician hopes to
continue her father's
legacy by getting to know
her patients and providing
superb care, but man-
aged care threatens
that dream.*

By Julia E. McMurray, M.D.

"Hello, Miz Lucy," I would say as my father led me into the patient exam room. Miz Lucy, a diminutive retired schoolteacher, would be sitting in the chair, gussied up to the nines, with gnarled hands and feet shod in heavy stockings and thick orthopedic shoes. My father, a general internist in a small Southern town, would have me touch her swollen hands as he injected the gold that would help her pain. She would exclaim about my growth, my successes in school, and would mention how the good doctor had saved her life more than once. Later, she would drive by our house in her ancient green Cadillac to make sure that he was home in case she needed him or to drop off her special cookies. At Christmastime, our kitchen counter was always covered with cakes, pies, or crocheted afghans made by grateful patients like Miz Lucy.

I remember making a house call with my father on a wintery Sunday afternoon. We drove up to a small house in which a sad, weathered-looking man with slumped shoulders sat in a wheelchair.

"Arthur," my dad would say as he took off his coat and opened up his massive black bag, "how are you?" And the murmuring would start. I would sit on the sofa in the quiet, empty house and watch as my father talked with Arthur. Later,



ILLUSTRATION BY JANE MJØLSNESS

on the drive home, my father would tell me how, as a young man, Arthur had dived into a quarry pond and severed his spinal cord.

And then there was Margaret. Struck down by polio at the age of 9 in a tiny farm town up in the county, Margaret survived in an iron lung; her brother had died. Her mother had cared for her all her life, even moving to a major university town long enough to help Margaret get a college degree. Margaret, only her head visible while her wasted body was encased in the huge tubular machine, would ask me about my latest book while my father inspected her mother's diabetic foot ulcer or assessed Margaret's recurrent parotitis. Margaret's mother eventually developed dementia and, before she died, cursed the daughter whom she had cared for all her life. To this day, my now-retired father still visits weekly, to discuss books, to bring medicines. I still visit at Christmas with my father, taking my children along with me.

These memories are my most enduring and are at the heart of why I became a physician. Now, after nearly 15 years in various practices, having raised my children and finally settled down in a group practice of dedicated, like-minded colleagues, I am glad that I kept the name that connects me to my father and to his legacy of doctoring. I have a dream and the guts to begin to fulfill it, a dream of building a practice with my Miz Lucys and Arthurs and Margarets. My dream is to provide superb medical care as I get to know them over time, to be their physician in my sense of the word, and to grow old with them.

But managed care is threatening that dream. "Growth and profit," the business executive writes on the blackboard as he explains that the practice of assigning patients to individual physicians has been abolished and that patients may sign up with any physician, regardless of known waits for routine or urgent care.

"For a panel size of 4,000, we will pay you X more dollars in salary than for the current 2,000 patients you are managing," he intones. Our protests are not acknowledged, and our reluctance to add more patients to already jammed practices is seen as "slothful and needy."

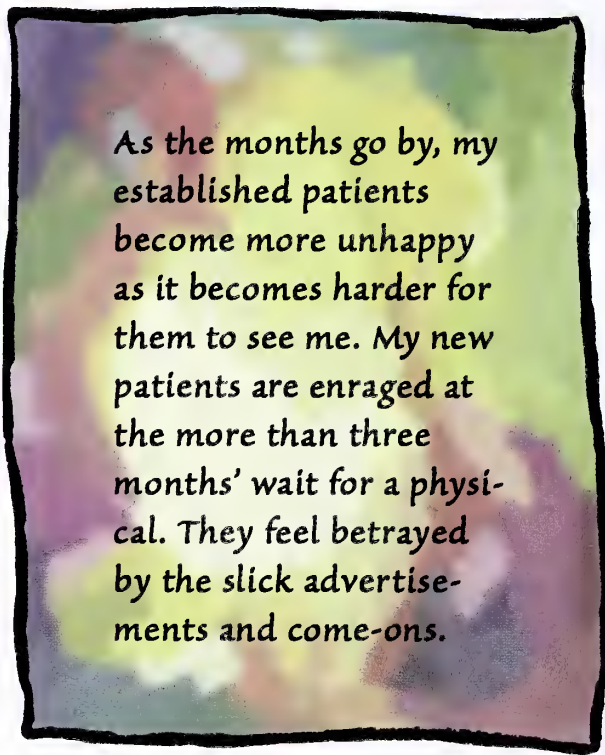
As the months go by, my established patients become more unhappy as it becomes harder for them to see me. My new patients are enraged at the more than three months' wait for a physical. They feel betrayed by the slick advertisements and come-ons. In the office, they sit with lists written on the backs of envelopes to remind them to discuss their headaches, constipation, elevated

cholesterol, and hormone levels. There just doesn't seem to be enough time for them to begin to trust me, nor for me to understand the person behind the list. I dread looking at my daily schedule and long for the short, uncomplicated medical encounter. My face no longer lights up in anticipation of opening the hand-written letter in my mailbox. Nowadays, these are much less likely to be testimonies to my care and much more likely to be complaints about the referral, the waits, or the most recent visit.

My Middle Eastern patient comes to see me. As always, she wears traditional Muslim clothing, her round face peering out of her headress. Widowed and alone, she is suing her employer for sexual harassment in a long, arduous battle that

will determine whether she can continue in the research career that she loves. I have been so impressed with the pluck and courage of this shy, lonely woman fighting to survive in a radically different culture. Our visits usually move quickly through the hypertension and the knee pain to the real reason for her visit: my support, my affirmation, and my reassurance that she will be all right. I see the hurt in her eyes as I am pushed for time one day and brusquely cut short our discussion.

A new patient calls me on the phone. She has menstrual irregularities, insomnia, and mood swings, and the



As the months go by, my established patients become more unhappy as it becomes harder for them to see me. My new patients are enraged at the more than three months' wait for a physical. They feel betrayed by the slick advertisements and come-ons.

suspicion that she is menopausal has added the stress of a major life transition to her already present difficulties. The wait for an appointment with me is unacceptably long to her. Although I have never seen her, on paper I am already her physician, and she is angry and irritated. I call her back, having already added extra patients to my session that day. Sitting in my office with my elbows on a stack of charts that all bear notes asking me to call patients, I am overwhelmed and vaguely realize that our conversation hasn't gone well. Many weeks later, when we finally meet, my new patient forcefully condemns my lack of compassion on the phone and is uninterested in both my abject apologies and my explanations about "HMO panel sizes" and "time pressures." I know that she has labeled me arrogant and insensitive, and the sense of failure on my part is enormous. Although I spend time rationalizing and working through the experience, her diatribe against me remains one of the most painful moments in my 15 years of doctoring.

I begin to feel as if I am in a war. I speak out at meetings but feel small and unheard. I want to ask the

managers and my bosses, "Where do you get your health care, and if your elderly mother is ill, do you want her to see the kind of physician you are attempting to create?" It is the practitioners and patients who will reap what these corporatized leaders have sown.

What about my dream? It has nothing to do with income, with status, or with having built a more cost-effective medical machine but is about the deep satisfaction that my interpersonal relationships and skills with my patients over the years will bring. Above all else, the physician-patient relationship must be preserved. I do not see this happening, despite my dedication to it and my efforts to sound an alarm and rouse my colleagues to action. I feel a helplessness as I face this inexorable attack. I am simply heartsick.

MM

Julia McMurray is a physician at the University of Wisconsin School of Medicine.

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The Case for Physician Practice Management Companies



By Richard L. Reece, M.D.

And Why They Haven't Taken Hold in Minnesota

Editor's Note: Always one to keep an entrepreneurial eye on trends in the medical marketplace, Dr. Richard Reece has made it his business to keep close tabs on physician practice management companies. For the last two years he's been editor-in-chief of *Physician Practice Options*, a monthly newsletter featuring, among other subjects, articles and a regular column on PPMs. He also cofounded and now chairs the National Association of Integrated Health Organizations. The group holds national conferences to connect would-be investors with capital-seeking physicians and PPM execs. It also publishes a monthly newsletter, *The PSO-IHO Report*, which tracks the evolution of provider-sponsored organizations and integrated health organizations, such as PPMs.

Dr. Reece believes the jury is still out on whether PPMs are a smart option for physicians. Here, he cites some of their advantages, describes their growth nationally, and discusses why they're a tough sell in Minnesota. Some industry watchers question the value of PPMs. An accompanying article, page 22, claims PPMs aren't living up to their lofty expectations. ➡

In less than 10 years, physician practice management companies (PPMs) have sprung onto the health care scene, promising relief from managed care pressures and financial boons for physicians. PPMs are independent companies that offer working capital, information systems and processing, and administrative, legal, financial, and business services physicians need to survive in the managed care environment.

As physicians strive to ease their administrative burdens, access capital, or cash out their practices, many are turning to PPMs. Two successful PPMs are PhyCor, a multispecialty company based in Nashville, Tennessee, and American Oncology in Houston. Both have maintained P/E ratios over 20, well above the average S&P ratio of 12, and have sharply increased the net worth in stock value of participating groups.

Appeal of PPMs

PPMs empower physicians by providing them with a relatively inexpensive source of capital—money invested in publicly traded companies. This infusion of capital allows groups of physicians to consolidate into more efficient organizations that can afford to hire professional managers and managed care consultants, acquire information systems, and achieve the market power and economy of

scale to generate better terms, such as higher capitation rates and less expensive supplies.

With these advantages, physician groups can compete on a level playing field with managed care companies and hospital systems. As an added benefit, PPM stock increases physicians' net worth and provides a financial retirement vehicle.

PPMs also appeal to investors—who believe in free-market, “brass-knuckles competition” and view organized physician companies as key to reducing health care costs, assuring quality, and building market share.

PPM Growth Nationally

The \$200 billion “physician services market” accounts for 80 percent of the spending in the \$1 trillion medical economy.¹ According to the investment firm Piper Jaffray Inc., “[This] market is large and growing. It is also highly fragmented. Pressures to consolidate are mounting. There are clear opportunities to improve the quality and reduce the costs of health care in the United States (and around the world). Physicians are central to achieving this vision. However, a fundamental restructuring of the physicians' services market must occur.”²

Brooks O'Neil and Brett Manderfeld, Piper Jaffray's PPM analysts, encourage physicians to join together to form structured, market-oriented business entities—which seems to be happening. By almost any criteria, PPMs are growing explosively (see Table 1). Since the late 1980s, and especially since 1994, PPMs have grown annually to become a major national health industry.

Table 2 lists the 11 largest PPMs at the end of 1997. While the biggest PPMs are multispecialty groups, the most recent entrants into the field have been specialty companies. All the PPMs listed in the table come out of



Table 1

Growth of PPMs by Various Criteria

Year	Number of physician practices acquired		Capital raised for PPMs by public sector	Number of publicly traded PPMs		Health care venture activity, number and value of deals	
1993	4	single specialty	\$154 million	6	single specialty	—	—
	22	multispecialty		5	multispecialty		
1994	37	single specialty	\$265 million	9	single specialty	45	\$241 million
	63	multispecialty		11	multispecialty		
1995	80	single specialty	\$739 million	14	single specialty	123	\$542 million
	68	multispecialty		15	multispecialty		
1996	124	single specialty	\$1,917 million	17	single specialty	210	\$1,107 million
	91	multispecialty		16	multispecialty		
1997	170	single specialty	\$2,659 million	21	single specialty	260	\$1,216 million
	130	multispecialty		17	multispecialty		

Source: Townsend Frew & Co., an independent investment banking firm headquartered in Durham, North Carolina.

the South and West, areas with pro-business climates and few reservations about for-profit health enterprises.

On this last point, O’Neil and Manderfeld comment: “Many health care organizations (primarily hospitals and health plans, but some physician organizations as well) have been granted ‘not for profit’ (NFP) status. This somehow suggests they operate on a higher plane, delivering needed services and pricing them without regard for ‘bottom line’ considerations. Practically, we find NFP often translates into NFT, ‘Not-for-Taxes.’ We also find the very real pressures of ‘for-profit’ often result in sharply more attention to detail and the provision of higher quality, lower cost services.”²

For-profit critics consider the last statement debatable, i.e., whether for-profit entities deliver higher quality and lower costs. For-profit advocates counter by saying that not-for-profit organizations provide no taxes for the community and show scant evidence of lower prices or higher quality.

Anyone who doubts the importance of the tensions created by conflicting philosophies and vested interests of the for-profit and not-for-profit camps need only revisit the Columbia/HCA debacle.³

PPMs Mean Business

In any event, PPMs are business corporations. They are publicly traded on Wall Street or are positioned for initial public offerings (IPOs). A few are privately held. *PHO Update*, an industry newsletter, counts 182 PPMs. But most experts focus on the 54 publicly traded PPMs, comprising 37 single-specialty and 17 multispecialty companies, and on the 78 PPMs now in the IPO queue.

In 1997, PPMs attracted \$2.7 billion from the capital markets, an increase of 38 percent over 1996.⁴ More than 40,000 of America's practicing physicians (8 percent) are affiliated with PPMs. Peter S. Stamos, director of Stanford University's Comparative Health Research Center, predicts that the PPM industry could capture one-third to one-half of the physician services market—meaning \$70 to \$100 billion in annual revenues—within five years.⁵ Jason Rosenbluth, a physician-turned-analyst at Volpe, Welt & Co. in San Francisco, is even more bullish: "I'm convinced the PPM is not only here to stay—it will become the center of the health care universe."⁵

PPMs Don't Live Up to Everyone's Expectations

PPMs aren't for everybody.

- Hospitals don't like them because they vie for physicians' allegiance, siphon ancillary revenues, take

Table 2

Physician Practice Management Industry Size

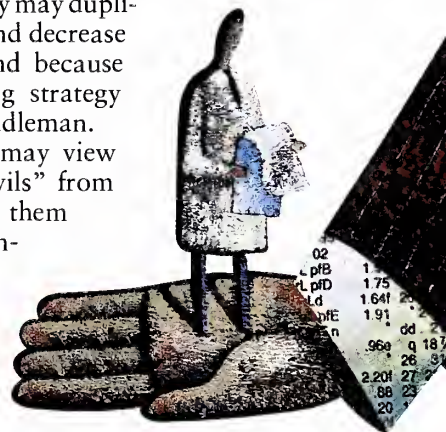
Based on revenue (dollars in millions)

Size Ranking	Company and location	1997 revenue
1	MedPartners, Birmingham, AL, multispecialty, 1992	\$6,932 million
2	FPA Medical Management, San Diego, CA, primary care, 1986	\$1,166 million
3	PhyCor, Nashville, TN, multispecialty, 1988	\$1,120 million
4	Coastal Physician Group, Inc., Durham, NC, emergency department, 1989	\$448 million
5	Physician Resource Group, 1993, Dallas, TX, ophthalmology, 1994	\$410 million
6	PhyMatrix, West Palm Beach, FL, multispecialty, 1994	\$347 million
7	American Oncology, Houston, TX, oncology, 1992	\$322 million
8	Physician Reliance Network, Dallas, TX, oncology, 1993 (Has group in Minneapolis)	\$317 million
9	Pediatrix, West Palm Beach, FL, neonatal intensive care, 1979	\$129 million
10	ProMedCo, Fort Worth, TX, multispecialty, 1993	\$128 million
11	Orthodontic Centers of America, Dallas, TX, orthodontic surgery, 1989	\$117 million

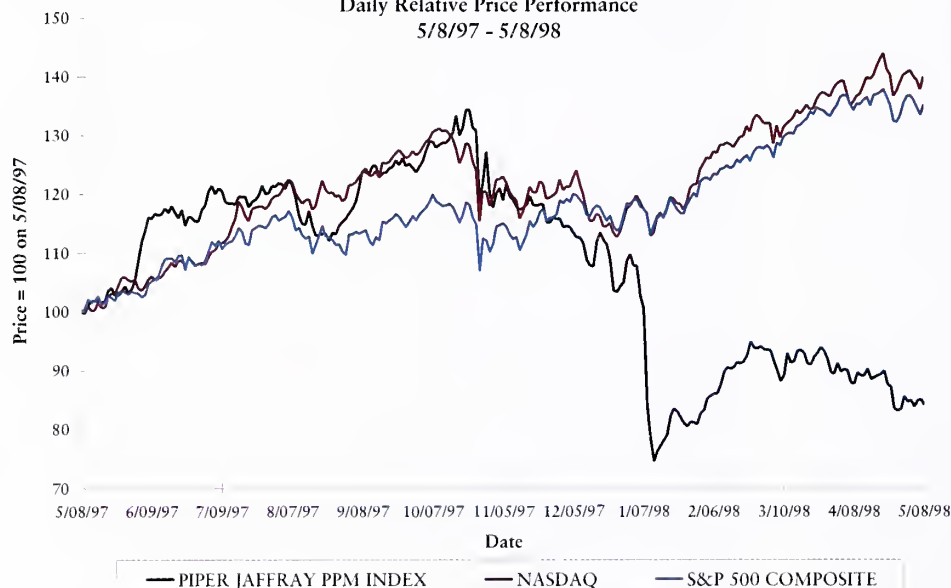
money out of the community, compete for managed care contracts, and threaten the hospital's primacy as the center of the health care universe.^{6,7}

- HMOs don't like them because PPMs can negotiate from a position of strength, because they may duplicate HMO functions and decrease HMO profitability, and because their direct contracting strategy cuts out the HMO middleman.

• Physicians, who may view PPMs as “business devils” from out of town, don’t like them because of 40-year contracts, fear of loss of control, failures to deliver “value” to groups, and stock price volatility when PPMs do not meet quarterly earnings



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projections. One respected physician practice newsletter, *The Physician's Advisory*, warns physicians not to sell to PPMs.

- Wall Street investors haven't liked PPMs in recent months.

Piper Jaffray analysts explain this skittishness in a March 23 letter to potential PPM investors: "As the enclosed chart details [see updated chart above], PPM stocks have been hammered over the past several months. The most recent catalyst was the announcement and termination of the proposed merger between PhyCor and MedPartners. Investors were spooked when the two larger players in this young niche failed to combine, and they were further unnerved when both companies announced changes in earnings in conjunction with the breakup of the transaction.

"Despite the recent carnage, or perhaps because of it, we remain excited about the outlook for leading PPMs. The bloodshed has begun to separate the wheat from the chaff. It has caused all PPMs to rethink their positioning and strategy. It has also created values in the stocks not seen in several years.

"The question at this juncture is, 'What's next for PPMs?' The answer is there will be winners and losers. Winners will build infrastructure to support controlled, profitable growth."

Two recent front-page articles in the *Wall Street Journal*, however, discuss the dangers of doctors hooking up with PPMs. The first article, "Texas Doctors Learn the Perils of Linking Fate to a Corporation,"

cites the case of an Austin, Texas, ophthalmology group that lost control of its financial destiny. The second article, on May 4, "PhyCor Tries to Mesh Doctor Practices, Finds It 'Like Herding Cats,'" details how PhyCor clinics in Jacksonville, Florida, Fort Smith, Arkansas, and Chickasha, Oklahoma, are in open revolt against their owners.

Limited Growth in Minnesota

PPMs may have a bright future elsewhere, but perhaps not in Minnesota, where they have made only limited inroads. Three PPMs do business in Minnesota: Physician

Reliance Network, Inc., an oncology PPM; Vision 21, Inc., an eye-care PPM; and American Dental Partners, Inc., a dental PPM. All are in Minneapolis. Only 34 physicians (0.3 percent of Minnesota practitioners) have joined PPMs, compared with 42,000 (8 percent) of practicing physicians in the United States.

Here's a brief rundown on the Minnesota PPMs:

- Physician Reliance Network, Inc., traded on the NASDAQ exchange, is an oncology PPM based in Dallas, Texas. Two and a half years ago, the company signed a long-term management services contract with the 23-physician Minneapolis oncology group Minnesota Oncology Hematology, P.A., which has grown to 26 oncologists. With capital from its corporate parent, the Minneapolis group is opening an 18,000-square-foot cancer center in Maplewood this summer.

Physician Reliance Network estimates its nationwide market at \$35 billion and says it is growing quickly as the population ages. The company has built fully integrated networks of outpatient oncology care, providing capital, facilities, administrative and technical support, and ancillary services to member physicians. Affiliated physicians provide all aspects of care related to cancer, including medical oncology, radiation oncology, and diagnostic radiology. The company currently manages the practices of 326 physicians in 121 locations, including 24 cancer centers like the one opening in Maplewood.

- Vision 21, Inc., traded on the NASDAQ exchange (stock symbol EYES), is based in Largo, Florida. The company estimates the total U.S. eye-care market at

\$31 billion. A year ago, Vision 21 acquired Minnesota Eye Consultants in Minneapolis, a group of eight ophthalmologists led by Richard Lindstrom, M.D. This group has a central office near the Phillips Eye Institute and other offices throughout the Twin Cities metro area.

Vision 21's Local Area Delivery System (LADS™) operates as a vertically integrated pyramid with four tiers: the bottom tier includes retail optical centers and optometrists; the second tier is cataract surgeons and general ophthalmologists; the third tier is subspecialty ophthalmologists (oculoplastics, neuro-ophthalmology, cornea/refractive surgery, glaucoma, retina/vitreous disorders, and pediatrics); and the top tier is ambulatory surgical centers equipped with Excimer lasers and other sophisticated equipment.

Vision 21 brings mobile Excimer lasers to satellite clinics in Elk River, Willmar, St. Cloud, Mora, Sandstone, Cambridge, Owatonna, Thief River Falls, and Farmington, as well as Eau Claire, Wisconsin. It also owns a retail optical chain in Milwaukee, Wisconsin, Stein's Optical, with 16 outlets. The Minneapolis group

envisions that the company will eventually be able to accept capitated specialty carve outs. A network of 46 ophthalmologists and 200 optometrists in surrounding states has been set up in anticipation of capitalizing on these capitated contracts.

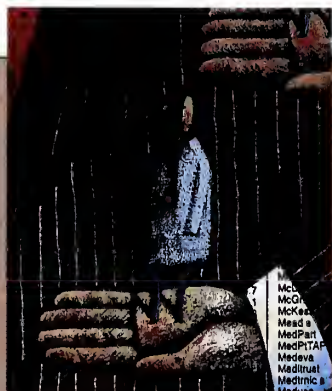
• American Dental Partners, Inc., is a multidisciplinary dental company taken public in December 1997 by Alex Brown, BankAmerica, Robertson Stephens & Co., and Piper Jaffray. According to American Dental Partners, the dental market is \$46 billion and will reach \$79 billion by 2005. The company manages 83 dental facilities in Arizona, Texas, Louisiana, Minnesota, Wisconsin, Massachusetts, and Pennsylvania. The Minneapolis-St. Paul market includes 34 dental facilities.

Why PPMs Haven't Taken Off in Minnesota

I see four major reasons why PPMs have been slow to take root in Minnesota:

1. Minnesota has a reputation as a mature managed care market. Mature markets have slim profit margins. In addition, Minnesota is one of the few states that





Affiliating with a PPM

So what are “independent” physicians to do, i.e., those of you not beholden to large hospitals or health systems, who don’t relish working for large, vertically in-

integrated organizations, and who want to control your financial and clinical destiny?

The problem is that you lack capital to hire professional management, bring in managed care expertise, and buy or lease the information systems you need to compete effectively for managed care business.

Fortunately, there's a solution—getting capital from physician-friendly financial partners. Those partners may include banks, venture capitalists, hospitals, a PPM, or a subsidiary of the medical association. Identifying the right partner is very important. In my experience, doctors don't want to put their personal assets at risk to get a bank loan, they find venture capital too expensive, and they don't feel comfortable being owned by the local hospital. Hospital-doctor partnerships are so fragile, says Princeton economist Uwe Reinhardt, that "it's like driving a nitroglycerin truck with a drunk

driver at the wheel." The recent implosion and collapse of integrated systems at Presbyterian Hospital in Dallas and the Tucson Medical Center in Tucson, Arizona, are examples of this fragility.

That leaves two possibilities—a PPM or a local medical society-sponsored management service organization (MSO).

To gain favorable terms with a PPM, you need to have an integrated group of 10 or more physicians. You should have significant market presence (at least 20 percent) or the potential to achieve it. You should also have a positive financial track record, committed physician leaders, and an unassailable specialty niche or a focused primary care strategy. If you object to "for-profit" activity, or if you fear hospital, peer, or HMO disapproval or reprisal, you may want to consider an MSO.

Because of their political nature and their need to satisfy multiple constituencies, medical associations aren't usually the ideal vehicles for achieving business purposes, such as raising capital or building business organizations. But some medical societies can create for-profit subsidiaries that serve as PPMs. The capital to form the subsidiary could come from a PPM, a pharmaceutical company, or a capital-rich, physician-owned entity, such as a captive physician-owned insurance company.

-RLR

-RLR

forbids for-profit HMOs, which is curious since it serves as headquarters for United HealthCare, the nation's largest for-profit HMO and one of Minnesota's largest employers. These two factors make doing business in Minnesota difficult for PPMs.

2. Minnesota doesn't offer optimal conditions for rapid PPM growth. These conditions include independent primary care groups not tightly bound to hospitals and the ability to capture capitated contracts. Most primary care physicians are already "spoken for"; indeed, an estimated 70 percent are already employees. Few Minnesota insurance companies, HMOs, or self-funded corporations want capitated contracts, since they've traditionally made money on discounted fee-for-service and see no reason to change.

3. Minnesota physicians may feel they simply don't need what PPMs have to offer—group formation, infrastructure development, organization of primary care physicians, managed care expertise, ancillary revenue enhancement, and physician recruitment and expansion. After all, nearly 60 percent of Minnesota's physicians practice in groups of 100 or more, and most primary care doctors are already spoken for by large systems. Twenty-

five years of managed care has built a foundation of managed care expertise, and large hospital and health systems have locked up ancillary revenues or can boycott new entities who even think about poaching. Many physicians are so discontented that a kind of functional rigor mortis has set in.

4. Minnesota physicians do not make strong PPM prospects. A May 1998 article in *Physician Practice Options* reported on the unhappiness of Minnesota physicians, their domination by large plans, their failure to form substantive business relationships with one another, and the challenges presented by managed care.⁸

Large health plans and systems have so dominated Minnesota, employing so many physicians, that physicians have missed the chance to develop clinical and business organizations of their own. The result is that physicians across Minnesota have yet to find common business interests and an organizational vehicle that will give them leverage with integrated systems, health plans, and business coalitions. In general, PPMs are reluctant to deal with disorganized physicians who are pessimistic about any business structure rescuing them from managed care malaise.

The Future of PPMs in Minnesota

Given these conditions, what's likely to happen in Minnesota with respect to PPMs? Multispecialty PPMs are not likely to enter the market because of negative perceptions, because "it's too late," because ancillary revenues aren't possible, because projected margins are slight, and because hospitals and health systems have cornered the supply of primary care physicians. Specialty PPMs, however, will enter the market vigorously to pursue entrepreneurial ventures, exploit hospital revenues, and cut deals with hospitals.

PPMs are experiencing growing pains in Minnesota, but I'm optimistic that these new businesses will expand. PPMs have learned from their mistakes and now offer physicians a greater stake in equity. I also expect large health systems to turn over management of salaried physicians to PPMs. This means of stemming losses is an integral part of the growth strategy of PhyCor, PhyMatrix, and MedPartners.

The recent move by the Buyers Health Care Action Group to break up the Minnesota health care oligopoly's power by cutting out HMO middlemen is a positive sign.^{9,10} Most important, Minnesota physicians have finally awakened to two powerful realities: 1) the absolute necessity to work together to build business organizations across geographic and systems lines; and 2) the compelling need to acquire the capital, expertise, and infrastructure needed to compete with HMOs and integrated systems.

MM

Richard Reece, editor-in-chief of Minnesota Medicine from 1975 to 1990, now lives in Old Saybrook, Connecticut, and is chair of the National Association of Integrated Health Organizations and editor-in-chief of Physician Practice Options, a national newsletter addressing managed care issues.

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Like for-profit hospitals and HMOs, PPMs are having a hard time living up to their lofty expectations.

Analyzing *the* PPM Portfolio



Therefore, doctors need to exercise caution in deciding whether to affiliate with a PPM, experts say.

By Cathy Tokarski

in 1998, says Larry Marsh, a director at Salomon/Smith Barney, an investment banking firm in New York. "The company took the opportunity to write off as much as it could in the fourth quarter," he says.

The challenge now for these companies—and for the PPM industry as a whole—is how to regroup and move on. PPMs, which acquire doctor's practices (or their assets) and manage them in exchange for a set fee, are built on the concept that doctors need management and financial backing to keep their practices viable in a world increasingly dominated by managed care.

As an industry, though, PPMs have lagged behind the rest of the stock market since mid-1996 and are off to a comparatively weak start in early 1998, according to data from Vector Securities International, an investment banking firm in Deerfield, Illinois. The stakes for doctors in the future of these companies are considerable—some 16,800 non-IPA physicians were affiliated with one of 32 public PPMs by the end of 1997, according to the Sherlock Co., a Philadelphia-area health care research firm.

Some critics assess PPMs harshly. The PPM industry is "a house of cards,

and I think they're all going to fall apart," predicts Alan Gassman, an attorney in Clearwater, Florida, who represents several physicians involved in a contract dispute with one PPM company.

Others insist PPMs are simply facing the inevitable growing pains of a young industry. "The underlying case for PPMs is so compelling for the delivery of health care that they are going to continue to exist and be significant," says Jack McGowan, a portfolio manager with Clover Capital Management, Pittsford, New York.

Industry Leaders Stumble

Opponents and supporters of PPMs agree that these companies are facing an array of higher operational and regulatory hurdles that are testing their abilities to deliver on their promises.

While industry analysts aren't sure whether the decision by PhyCor and MedPartners to call off their merger will have any bearing on PPMs' long-term prospects, the news of the breakup and the subsequent disclosure of both companies' financial problems have certainly thrown the industry for a loop.

Lately, the smart money is riding on health care's naysayers and not its hypesters.

Within the past several months, the stocks of formerly high-flying public companies such as Columbia/HCA, Oxford Health Plans, and PacifiCare have plummeted on the news of lower-than-projected earnings due to serious operating problems and financial shortfalls.

Like big for-profit hospital chains and aggressive health maintenance organizations, physician practice management firms and their lofty promises have also been called into question.

An unmistakable sign that the PPM industry has been blown off course was the January 7 termination of the proposed merger between PhyCor and MedPartners, the nation's No. 1 and No. 2 PPMs. Then, on March 18, MedPartners announced fourth-quarter 1997 net losses of \$840.8 million, including pre-tax charges of \$646.7 million related to the cost of restructuring and closing 84 clinics with 238 physicians, among other factors.

The massive fourth-quarter charges, more than four times the \$145 million loss MedPartners officials had predicted in early January, "can be seen as a clearing of the decks" to make way for a more stable performance

"If the perceived market leaders can't get it right, who the hell can?" asks Gautam Prakash, an associate at Bessemer Venture Partners, a venture capital firm in Wellesley, Massachusetts.

Indeed, Nashville-based PhyCor announced for the first time in its history that it would take a \$22 million charge in the first quarter of 1998 for the cost of restructuring five newly formed multispecialty clinics and for divesting two additional clinics with 70

physicians. The company also took a \$15 million charge to earnings related to the cost of the failed merger negotiations with MedPartners. PhyCor ended 1997 with net earnings, excluding the one-time charges, of \$57 million, compared with \$36 million in 1996.

"What we've concluded from this journey of the past several months is that we're on the right track, and we need to stay focused," says Paul Keckley, PhyCor's vice president of strategic development. ➔



ILLUSTRATIONS BY KEITH SKEEN

Conservative financial reporting that does not overstate net revenues and careful acquisitions that favor physician and hospital partnerships over specific market locations are the company's key strategies this year, Keckley says. "We do not have a war room where there's 50 markets we have to go to."

Specifically, PhyCor will focus on acquiring assets of small to mid-sized multispecialty group practices, managing IPA physicians who do not want to join a group, and taking over the management of physician practices acquired in recent years by hospitals, which have lost millions of dollars in their bids to employ doctors. "The employment model doesn't work—it's almost overwhelming," Keckley says.

Smaller Is Better

Given the recent grim financial news, the outlook at MedPartners remains turbulent, and questions persist about whether the worst of the company's troubles are over. The Birmingham, Alabama-based company manages 13,531 physician practices, owns Caremark Inc.—one of the nation's largest pharmacy benefits management companies—and has contracts with Aetna U.S. Healthcare to serve enrollees in certain markets.

Merger negotiations with PhyCor ended the same day that MedPartners revealed it was forced to take a \$145 million pre-tax charge to earnings to pay for unexpected utilization and medical costs in a new open-access product launched in 1997 and for the termination of a mail-order pharmacy business. Other factors that contributed to the final \$646.7 million pre-tax charge included shuttering the 84 clinics, many of which are smaller physician practices in Southern California; restructuring agreements with other clinic operations; and writing down the value of assets that did not live up to the company's expectations. Earnings this year are expected to fall 30 percent below analysts' earlier predictions.

The company buried the news of last year's dismal performance deep inside a news release announcing the new appointment of MedPartners President and CEO

MacCrawford. He replaces Richard Shrushy, who served as the company's interim head following the mid-January ouster of company founder Larry House.

A certified public accountant, Crawford is credited with turning a troubled psychiatric hospital chain, formerly called Charter Medical Corp., into a managed care company in the early 1990s. The company, Magellan Health Services, specializes in disease management.

"Most of us are pleased with the selection," says J. Michael Condit, M.D., board chair of Kelsey-Seybold, a 240-physician group practice owned by MedPartners in Houston. Crawford's track record in turning around a troubled company and his expertise in disease management will be major assets in his new job, Condit adds.

The company will continue to get help digging out of its financial hole from Shrushy, who remains chair of MedPartners' board of directors. Shrushy's "nonsense" approach will ensure that the company's PPM, pharmacy, and hospital staffing divisions work

together more efficiently, Marsh says.

One thing is clear, however: Given its depressed stock price (9¹⁵/16 on May 4), MedPartners will make only selective acquisitions, not "big blockbuster deals" in new markets where the company has no existing relationship with physicians or payers, Condit says. But acquisitions that were planned before the company's latest financial disclosure are going forward, he says.

Both MedPartners and PPMs have entered a "maturing" phase that will emphasize adding value to practices, not just creating larger groups, Condit says. "The thing that is changing for all PPMs is that you will not see inflated values paid for practices," regardless of who is acquiring whom.

Part of the company's focus on value must include sound operational systems before demand for popular managed care products overtakes them. Clover Capital's McGowan notes that MedPartners launched a popular open-access product in California before it had the right information systems to monitor and manage



The thrill is gone

Stock value percentage change for nine leading public PPMs.

PPM	1997	YTD '98*
American Oncology	56%	-3%
FPA Medical	-17%	0%
IntegraMed	12%	7%
MedPartners	7%	-49%
Pediatric	16%	-9%
PhyCor	-5%	-5%
PhyMatrix	11%	-22%
Physician Reliance	35%	15%
Physicians Resource Group	-75%	-9%
PPM average	-1%	-12%

* As of March 12

Source: Vector Securities International, Inc.



utilization. "It's not surprising that things got out of control, but I don't think the concept was flawed," he says.

Bad Experience—Good Advice

As the PPM industry hits its share of detours in the road, doctors are in a better position today to take advantage of the experiences—of late, more bad than good—that others have gained. "While this looked to be an easy business to enter a couple of years ago, it's a lot more challenging today," notes Marsh. With that in mind, he suggests that doctors should consider doing the following:

- Talk to the physician leadership in the clinics that have been acquired by a PPM to find out whether the company promised too much and delivered too little, says Bessemer's Prakash. "Get comfortable with the

people you're dealing with," he advises, and recognize that "you may not sell your practice to the highest bidder."

- Understand how a company defines and brings value to a practice, says Keckley. Specifically, doctors need to know what the "payback" is for a group once it affiliates with a PPM, how the company achieves its return, and what role the physician group plays in that process.

- Read the "divorce clause," or the terms that allow a practice to break its contract (typically 30 to 40 years) with a PPM, Gassman says. "If it's not going to work, don't get married." MM

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Minnesota's New Rural Health School

The University of Minnesota's new Rural Health School in Duluth trains medical, pharmacy, nursing, and physician assistant students to work together in rural settings.

Byron J. Crouse, M.D., F.A.A.F.P., Derryl Block, R.N., Ph.D., Barbara Elliott, Ph.D., Tom A. Larson, Pharm.D., F.C.C.P., Dawn Ludwig, P.A.-C, M.S., and Walter Sweniko, M.D., M.S.

Shortly after starting her third year of medical school, Amy Rantala found herself sharing an apartment in Grand Rapids, Minnesota, with a classmate—a pharmacy student—and studying medicine in rural Itasca County. Not your typical med-school scenario, Amy's schedule includes working with students learning to be pharmacists, nurse practitioners, and physician assistants, as well as following physician preceptors in various specialties. She is a student in the University of Minnesota's innovative new Minnesota Rural Health School, which trains students in various health care fields to work as teams in rural settings.

Collaborative health care is the wave of the future for rural communities. Like their urban colleagues, rural practitioners are expected to offer state-of-the-art health care at a reasonable cost. That can be especially challenging in rural areas, where physicians tend to have little backup for treating patients and sharing call. Many rural communities are responding by recruiting a mixed group of practitioners, including physician assistants, advanced practice nurses, pharmacists, social workers, dietitians, physical therapists, and others.¹⁻⁴ In communities participating in the University of Minnesota's Rural Physician Associate Program, the number of physician assistants and advanced practice nurses has increased from 1.29 per community in 1994 to 4.37 in 1998.

However, few schools train physicians, nurse practitioners, and other providers to work as interdisciplinary teams in rural settings. In recent years, physicians and health maintenance organizations have told the University of Minnesota-Duluth School of Medicine that such training is needed. As a result, and with legislative support, the school has created partnerships with various health professional educational institutions and rural Minnesota communities to start the Rural Health School.

As part of the program, medical, nursing, pharmacy, and physician assistant students spend 12 weeks together in rural Minnesota communities learning collaborative care, conducting joint student projects, and engaging in case discussions and team-building activities.

"It has been an excellent experience learning how we

can utilize one another," says Rantala. "For example, I would feel confident consulting a pharmacist about which medication is best for a patient with diseases X, Y, and Z, and I have learned the scope of nurse practitioners' ability and training. I look forward to working with them in the future."

HISTORY

Although several educational initiatives in Minnesota have promoted a multidisciplinary team concept of health care delivery, interdisciplinary training has been lacking. Interdisciplinary care involves providers of different professions working together, effectively communicating, sharing responsibility for patient care, integrating ideas about patient needs and interventions, and respecting all team members.⁵

Rural initiatives that existed before the Rural Health School are highlighted in the sidebar, page 28. They include the Rural Physician Associate Program (RPAP) at the University of Minnesota Medical School, the Pharmacy Rural Education Program at the university's College of Pharmacy, the Physician Assistant program at Augsburg College, and the Collaborative Rural Nurse Practitioner Project and Interdisciplinary Partnerships for Training Project, both coordinated through the university's School of Nursing.

In December 1995, the University of Minnesota-Duluth School of Medicine initiated discussions between these programs and representatives from rural communities, hospitals, the Center for Rural Health, and managed care organizations to assess needs and make plans for a new Rural Health School. This group of about 20 people agreed that the Rural Health School would foster collaboration between disciplines, educational institutions, health care employers, and rural communities. The school's goals are outlined in the Rural Health School mission statement (see the table).

The program began during the 1996-97 academic year; four 12-week sessions have been held so far, and 43 students from 15 schools have participated. The rural communities and academic programs involved collabo-

Minnesota Rural Education Initiatives

Before the Rural Health School opened in 1996, many Minnesota programs were already underway to promote rural health care. Following are examples.

RURAL PHYSICIAN ASSOCIATE PROGRAM

The University of Minnesota's Rural Physician Associate Program (RPAP) was established in 1971 to address the shortage of family physicians and other primary care specialists in greater Minnesota. RPAP places 40 medical students in nonmetropolitan Minnesota communities for nine months of their third year. RPAP students experience firsthand the lifestyle of rural physicians by living, learning, and working with them. The long-term family practice experience reinforces the concept of "continuity of care" through students' observation of the natural progression of diseases and effectiveness of different therapies on individual patients and their families. Since RPAP's inception, 859 students have participated in 103 greater Minnesota communities. Of the graduated RPAP students now in practice, 67% are family physicians; another 9% practice in other primary care specialties. Overall, 61% are in rural practices, and 64% practice in Minnesota.

THE PHARMACY RURAL EDUCATION PROGRAM

The Pharmacy Rural Education Program (PREP) offered by the University of Minnesota's College of Pharmacy has promoted the "health care team" concept since PREP began in 1994. The very first PREP initiative allowed fourth-year pharmacy students to spend six months in a rural community pursuing an interdisciplinary curriculum with RPAP students, bringing together students with distinct, yet similar, educational backgrounds to study cost-effective alternatives to traditional health care in a rural environment. Students gain an appreciation of the strengths that each discipline brings to the health care team. The RPAP and PREP students attend hospital rounds, outpatient clinics, and extended care facilities together.

Other PREP programs give pharmacy students experience in a wide variety of rural health care settings. PREP has worked successfully with other disciplines in developing new models for providing pharmaceutical care in rural Minnesota, always promoting the return of pharmacy practitioners to rural communities.¹

AUGSBURG COLLEGE PHYSICIAN ASSISTANT PROGRAM

The Augsburg College Physician Assistant Program is the only physician assistant education program in Minnesota. The program's mission is in part "to educate students in a manner ... based on a foundation of respect and sensitivity to persons of all cultures and backgrounds and oriented toward providing care to underserved populations."² The program was established in 1995 and graduated its first class in August 1997. Of these first graduates, 27% are employed in primary care in rural Minnesota. The program admits 28 students per year, with the curriculum extending over 27 months. Students must complete at least one of their clinical rotations in a rural clinical site.

COLLABORATIVE RURAL NURSE PRACTITIONER PROJECT

The Collaborative Rural Nurse Practitioner Project, coordinated through the University of Minnesota School of Nursing, has been funded through the Minnesota Higher Education Coordinating Board since 1993. The nursing programs at the College of St. Catherine, College of St. Scholastica, University of Minnesota, Winona State University, Mankato State University, and Metropolitan State University work together to improve access to rural nurse practitioner education, develop rural practice education sites, and create opportunities for nurse practitioners to establish practices in rural communities.³

MINNESOTA PARTNERSHIPS FOR TRAINING PROJECT

Minnesota Partnerships for Training is an interdisciplinary project coordinated through the University of Minnesota School of Nursing. It has been funded through the Robert Wood Johnson Foundation since 1995 and adds the PA programs at Augsburg College and University of Wisconsin-La Crosse to the partners of the Collaborative Rural Nurse Practitioner Project.

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rate in planning and implementing the curriculum, which is intended to benefit the communities involved as well as train the students. Program evaluations show that students are gaining knowledge of rural health care, learning skills they need to work in interdisciplinary teams, and solidifying their interest in practicing in rural communities.

HOW THE PROGRAM WORKS

RHS recruits students from Minnesota's medicine, nursing, pharmacy, and physician assistant programs to enroll in 12-week sessions that take place in a rural community. Five rural communities are involved thus far: Moose Lake, Willmar, Itasca County, New Ulm, and Staples. The program typically sends one student per discipline to each site, depending on the number of students interested in the program.

RHS employs a practicing health professional from each discipline in the communities involved to act as community faculty for the program. It also employs academic faculty from the students' home schools. A site coordinator in each community acts as a liaison between the students, the faculty, and the community; helps implement the RHS curriculum; and assists students with scheduling and housing. In addition, each community has an advisory committee (see the sidebar, "The Moose Lake Experience," page 30) with local representatives from such areas as business, health care, and education.

Some communities arrange housing for the students. Most students spend the 12 weeks living in the community, although some commute. Currently, nursing students attend classes at their respective schools while participating in RHS, so they typically commute to the RHS sites.

Before each 12-week session begins, all students, site coordinators, and faculty meet during a two-day RHS orientation hosted each year by one of the RHS communities. The retreat is a venue for students and faculty to share expectations and information. Participants discuss rural communities and rural community health, interdisciplinary

care, and the use of communication technology.

The students then go to their assigned communities. The RHS students' community-based experience is two-part: 1) a joint curriculum for the various disciplines that involves sessions with RHS faculty each week, and 2) a discipline-specific curriculum that involves preceptorships with local providers in the students' respective fields. For the medical, pharmacy, and physician assistant students, these preceptorships are ongoing throughout the 12-week program. Most nursing students meet

Table

Rural Health School Mission Statement

The purpose of the RHS is the discovery and dissemination of knowledge aimed at enhancing the health of the people of rural Minnesota and the surrounding region. This mission will be achieved through the following goals (the numbered items) and evaluation methods (bulleted items):

Goal 1: Educate health professional students, providing rural role models and support at rural training sites to prepare students for eventual practice in rural Minnesota.

- Demonstrate knowledge of the culture, dynamics, health needs, and health care systems of rural communities;
- Understand the roles and contributions of health care team members and analyze the effectiveness of interdisciplinary teams in the community; and
- Demonstrate interdisciplinary team skills in delivering care to individuals, families, and communities.

Goal 2: Foster the selection and education of health professional students who wish to live and work in a rural community.

- Strengthen intentions to work in rural areas.

Goal 3: Promote interdisciplinary teams of health care professionals by teaching students skills needed to implement interdisciplinary approaches to health care in rural areas and by facilitating efficient and cost-effective interdisciplinary practice in rural settings.

- Understand the roles and contributions of health care team members and analyze the effectiveness of interdisciplinary teams in the community; and
- Demonstrate interdisciplinary team skills in delivering care to individuals, families, and communities.

Goal 4: Engage in community planning and development activities with rural communities to assist them in achieving the highest level of health for their citizens.

- Demonstrate knowledge of community partnerships and the planning process to promote health in rural communities.

Goal 5: Integrate state-of-the-art distance learning with traditional learning methods via innovative uses of technology and teaching techniques.

- Demonstrate knowledge and skill in using electronic communication technologies for education and patient care.

Goal 6: Provide graduates with information and guidance regarding professional careers in rural communities.

Goal 7: Facilitate education opportunities for practicing health care professionals in their rural communities as well as at academic sites.

Goal 8: Conduct research, especially in rural areas, to advance the health of the public.

The Moose Lake Experience

The success of the new Rural Health School (RHS), based at the University of Minnesota–Duluth, depends on collaboration between students, academic faculty, and rural communities. The collaboration is working in Moose Lake, where a local advisory committee provides a link between the community and the school. This group of about 20 individuals works with the RHS to identify local health needs, potential initiatives for the RHS student teams, ways to improve the RHS learning experience, and potential funding sources. Members represent business, county agencies, schools, ministry, service organizations, health care, and consumers. The committee meets with RHS students four times a year.

The Moose Lake Advisory Committee identified adolescent health needs, geriatric health needs, and compliance with medications as potential community projects for the RHS students to address.

During the 1997-98 academic year, the RHS students chose adolescent health needs for their community project. The team conducted focus groups with students from the local schools and surveyed other students to assess their health needs. After the RHS students presented their results to the advisory committee and other community groups, the community concluded that a more comprehensive study would be beneficial. The RHS students explored various options and, with community input, decided that a Search Institute Healthy Communities—Healthy

Youth community assessment was the best option.¹ RHS students met with community groups, including the city council, to present information about the possibility of a Search assessment. The community decided to establish a Search committee to plan activities that promote healthy adolescent behaviors. This project is now underway independent of the RHS.

This year's RHS students evaluated Moose Lake's geriatric health needs. They developed an inventory of existing and needed services to assist the elderly and published a list of services and phone numbers.

The Moose Lake community has helped to meet RHS needs. The school district and hospital together provided permanent housing for the program. The hospital supplied land and materials, and the high school vocational class built a house, which will be moved onto the hospital property this summer.

The community advisory committee helps RHS students select a project that benefits the community. In turn, the momentum generated by RHS projects helps the community determine and address its health needs. The system promotes community pride and enhances the students' learning.

1. Healthy Communities—Healthy Youth: A National Initiative to Unite Communities for Children and Adolescents. Available on the World Wide Web at <http://www.luthbro.com/youth/HCHY.html>

with a preceptor only a couple days during the session and return to their respective campuses for classes most days.

The preceptorships are coordinated by the various schools involved in the RHS. For example, Amy Rantala is in the University of Minnesota's Rural Physician Associate Program. She works with physicians of various specialties, such as family practitioners, general surgeons, and obstetrician/gynecologists, in Itasca County.

For the interdisciplinary curriculum, the students meet twice a week to work on interdisciplinary team training and a community project and to dialogue via e-mail and televideo with faculty at remote locations.

INTERDISCIPLINARY TEAM TRAINING

Interdisciplinary team training covers field activities, such as observing interdisciplinary teams in action, and classroom activities, such as team-building exercises and case studies that involve health care providers from multiple professions.

One example of a classroom activity is training in conflict resolution. Students complete questionnaires that assess their listening and communication styles and then discuss methods to resolve conflict based on their

individual styles. Or faculty may lead a case study with discussion on how providers in various fields could provide comprehensive and coordinated care for a patient. "It's fun to see the different approaches students take to patient care depending on their field—we all ask different questions and learn from each other," says Rantala.

For field activities, the students might follow a public health nurse and social services worker on a home visit to determine, for example, what local services could help an elderly patient continue to live at home.

THE COMMUNITY PROJECT

Each group of students conducts a community project in a subject suggested by the local advisory committee. For example, one community's advisory committee may decide that adolescent smoking and promotion of screening for cervical and breast cancer are high priorities in that community. The students would select one of these topics and do a community assessment and intervention.

Amy Rantala's team decided to address teen pregnancy, a particular concern in Itasca County. The RHS students visited four health classes at a local high school, where they taught contraception and held open forums

to discuss the problem. "It was especially rewarding later, when I treated one of the students for mono at a local clinic. When I asked him about sexual relations with his girlfriend, he said he felt comfortable talking with me because I had been open on the topic when visiting his health class," says Rantala. ("The Moose Lake Experience," page 30, describes another community project.)

ELECTRONIC COMMUNICATION

Another goal of RHS is to expose students to electronic methods of communication. The curriculum includes clinical case discussions between students and faculty at remote locations via televideo. Students also use this technology to communicate with their peers at other RHS sites. At the end of the 12-week session, each team presents its community project via televideo to the student teams at the other sites.

The students also learn to find medical information via the World Wide Web. "For the case studies, faculty often suggest Web sites that contain pertinent information," says Rantala.

In addition, each student is linked with a faculty member from a different health care discipline to dialogue via e-mail about rural care, interdisciplinary care, or other related issues. Both the students and the faculty generate questions.

The learning process in the RHS does not follow the usual didactic approach. Students are expected to learn from one another; faculty members facilitate discussions but aren't necessarily the content experts. This self-learning approach teaches students how to find and use community resources, which benefits them later when they're in practice.

RHS OUTCOMES

We began evaluating the RHS program when it started in 1996-97. We conduct interviews with students, faculty, and site coordinators after each session to discuss the curriculum, the teaching methods, the use of technology, effects on the RHS communities, and the overall experience. Following the first year's results, we made changes in the use of e-mail and televideo, developed new case studies, and revised the retreat syllabus.

Our evaluations show that the RHS experience has increased students' knowledge and skills in rural interdisciplinary health care, and more of the students now say they plan to practice in rural communities. Achieving the RHS community goals as outlined in the mission statement is also progressing. However, we are still working on ways to measure the program's impact in RHS communities.

We have begun a long-term follow-up evaluation of the RHS program. Past RHS participants will be contacted every two years (up to 10 years after RHS participation) to learn what jobs they have taken and where they are living.

THE FUTURE OF THE RHS

Several aspects of the RHS program need improvement.

First, the program must recruit a more balanced number of students. So far, the number of interested students has been greater for some disciplines than for others. To help recruit a greater number and diversity of students for all the rural sites, the dates of the fall session have been changed to reduce scheduling conflicts. Also, as the program grows, broader participation is needed. Plans are underway to add public health, social services, and possibly dentistry students to the RHS teams. We hope to expand to more communities as well.

Promoting an understanding of developing technologies, such as interactive television and computer access to medical databases through the World Wide Web, will continue to be an important feature of the RHS.

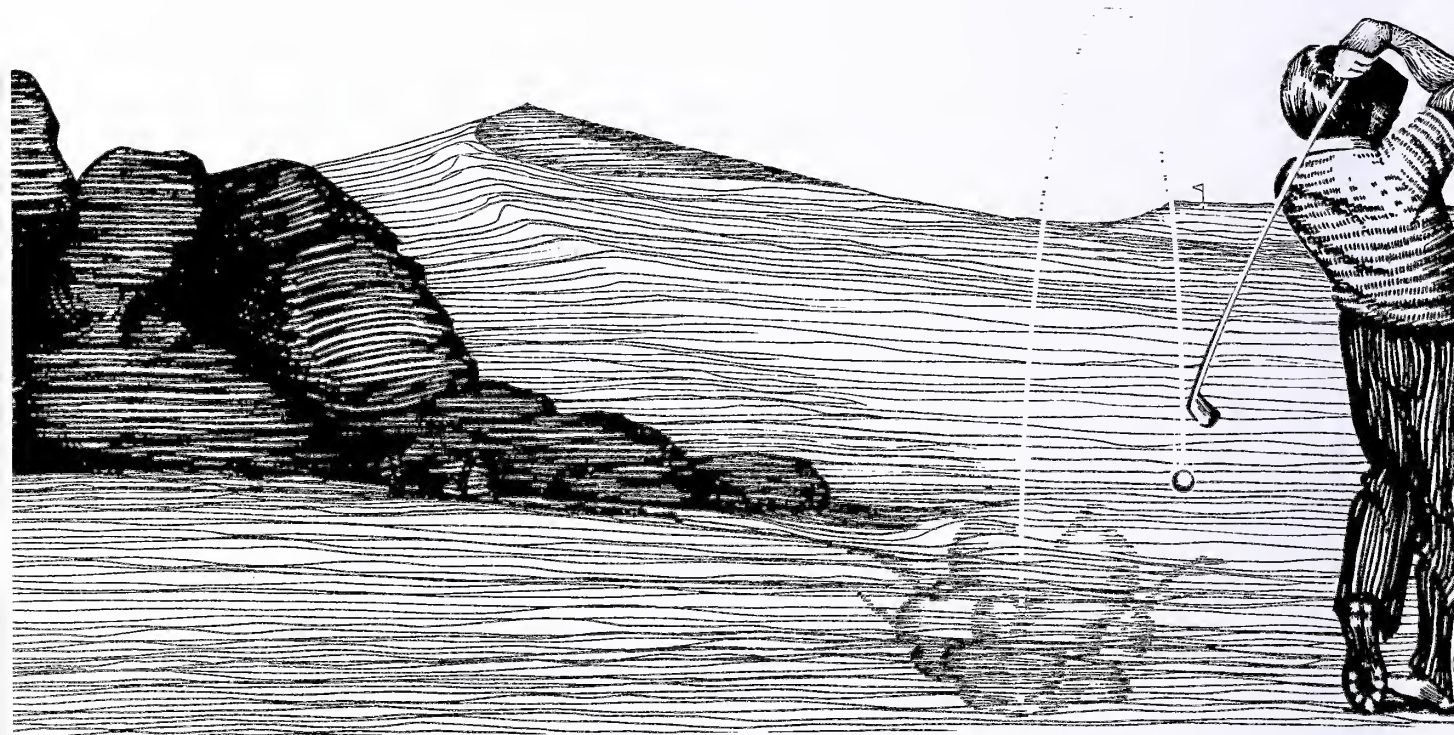
Although the program is still in the formative stages, Rantala is excited to be part of it. "This is an education you just can't get in the classroom. It's great to learn about the resources available in rural communities, such as interactive television, which will be a huge media for rural medicine in the future. I've gained great respect for the pharmacists and their vast knowledge of drug treatments, and I've learned to feel comfortable working with practitioners in various fields."

MM

Byron Crouse is director of the Minnesota Rural Health School and head of the Department of Family Medicine at the University of Minnesota-Duluth School of Medicine. Derryl Block is an assistant professor with the School of Nursing, University of Minnesota. Barbara Elliott is an associate professor in the Department of Family Medicine at the UMD School of Medicine. Tom Larson is an associate professor with the College of Pharmacy, University of Minnesota, and is involved in the Pharmacy Rural Education Program. Dawn Ludwig is director of the Augsburg PA Program, Augsburg College. Walter Swentko is director of the Rural Physician Associate Program with the University of Minnesota Medical School.

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MEDPAC ENDORSES NORM COLEMAN FOR GOVERNOR

The MEDPAC board announced in late May that it is endorsing St. Paul Mayor Norm Coleman in the Minnesota gubernatorial race.

Other Republican candidates vying for the governor's seat are Lt. Gov. Joanne Benson, former state Rep. Allen Quist, and businessman Dick Borrell. The DFL candidates are Attorney General Hubert Humphrey III, Hennepin County Attorney Mike Freeman, former state auditor Mark Dayton, former state Sen. Ted Mondale, Sen. Doug Johnson, and Sen. John Marty.

The board reached its decision after conducting a series of interviews and evaluating questionnaires completed by leading candidates in the race.

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MMA AWARD NOMINATIONS SOUGHT

The MMA will present several awards during the 1998 MMA Annual Meeting in October. The MMA Physician Communicator Award goes to a member who has shown "exemplary skills" in communicating with the public. The deadline for nominations is July 1. To submit a nomination, call Lorrie Holmgren at 612/378-1875 or 800/DIAL MMA (342-5662).

The Community Service Award honors an MMA physician who has an outstanding record of community service. You can find a nomination form in the May issue of *The Monitor*. The deadline for nominations is July 1. If you have any questions, call Karen Tourdot at 612/378-1875 or 800/DIAL MMA (342-5662).

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Calls for Endowment to Fight Tobacco Addiction

MMA President-elect Judith F. Shank, M.D., represented the MMA May 13 at a news conference organized by the Smoke-Free 2000 Coalition, at which public health advocates called for setting aside \$650 million of the \$6.1 billion tobacco settlement to create a permanent endowment to reduce tobacco use.

The \$650 million fund is written into the historic May 8 settlement but is subject to the Legislature's approval.

Only 11 percent of the money Minnesota will receive is accounted for in the terms of the settlement; the other 89 percent is up for grabs. Health care representatives at the conference stressed the importance

of urging lawmakers to stay focused on public health as they begin eyeing that 89 percent.

A. Stuart Hanson, M.D., president of the coalition, said spending \$80 million a year for smoking research and prevention through a non-profit endowment would put Minnesota "out in front" with states such as California and Massachusetts, where smoking rates have dropped dramatically due to comprehensive tobacco control programs.

The settlement also earmarks \$102 million for smoking cessation. In addition, tobacco companies will pay \$100 million (\$10 million a year for a decade) to fund a national research project based in Minnesota.

Tobacco continued on page 36



MMA Vice Speaker of the House Gary Hanovich, M.D., President-elect Judith Shank, M.D., and Smoke-Free 2000 President A. Stuart Hanson, M.D., celebrate Minnesota's public health victory.



Viewpoint

• • •

Kent S. Wilson, M.D.
President, Minnesota Medical Association

MMA Has Dual Mission—To Serve Physicians and Patients

The introduction of the MMA's new Center for Physician Advocacy reminds us of the primary mission of this association—to advocate on behalf of both physicians and their patients. In recent weeks, the MMA has had notable successes in both arenas.

Our victory in winning a delay of the Medicare evaluation and management guidelines and a promise of major improvements was significant. Of course, we didn't do it alone—the outcry against cumbersome, clinically irrelevant guidelines came from physicians throughout the country. But the MMA made sure the Minnesota perspective was heard.

After the MMA Board of Trustees took a firm stand opposing the guidelines, the MMA convened a Minnesota Summit where physicians gave specific ideas on how to improve them. Their ideas were echoed by physicians in other parts of the country and reflected in the revised framework, unveiled at the AMA "fly-in" in Chicago. Now the old 1997 guidelines are on hold indefinitely, and Minnesota physicians' concerns will be addressed in the final guidelines. The MMA will continue to be very active on this and all issues that affect the practice of medicine.

Currently, the MMA Center for Physician Advocacy is involved in AWARE contract discussions, and in the months ahead, the MMA plans

a major effort to ensure prompt payment of physician reimbursement.

Advocacy on behalf of our patients and the health of the community is an equally important part of our mission. The MMA has long been a leader in the fight against tobacco addiction. In 1984, we founded the Smoke-Free Coalition to bring together other groups that shared our vision of a smoke-free 2000. Since then the MMA has worked with the Coalition for clean air legislation and strong laws to keep children from buying tobacco.

When the federal government was considering a weak national tobacco settlement that would have prevented the FDA from regulating tobacco and kept the Minnesota lawsuit from going to trial, the MMA urged Minnesota's congressional delegation to hold out for a better deal. The MMA's firm approach helped slow down a national rush to settle that would have undercut our state efforts. Now we have reason to celebrate a landmark settlement. President Clinton told Attorney General Hubert Humphrey that Minnesota has set a "national and perhaps international standard."

Although the settlement is reason to cheer, it marks the end of round one rather than a final victory. There will be a struggle at the Legislature among many competing ideas about how to spend the money—from paying for a new stadium to

financing education. The rationale behind the lawsuit was that tobacco companies should help reimburse the state for the cost of treating people who suffer from tobacco-related illnesses, which amounts to about \$1.3 billion each year. The settlement will bring in less than 1 percent of that amount. The best use of public money will be to invest in programs that will reduce the smoking rate and thus cut health care costs for future generations. The MMA will work to make sure Minnesota's historic settlement is devoted to health care purposes rather than turning into a slush fund for a variety of projects.

Recently, MMA participated in a news conference to call for a very appropriate use of some of the settlement money—a permanent endowment that would serve as a gift of health to future generations (see page 33). The financial award gives us an opportunity to reduce tobacco addiction among current smokers and create an effective program to deter young people from beginning to smoke.

Such programs have proven successful in other states. California cut smoking by more than 40 percent in three years by raising the tobacco tax and using part of the money for public education. Minnesota should invest in a similar campaign of "counter advertising," as well as tobacco research and community grants for grassroots efforts. The Legislature would have to approve the proposal to use \$650 million of the \$6.1 billion settlement for the permanent endowment.

Next legislative session, the MMA will be involved in the debate over how to use the settlement money. Certainly it should be used for smoking cessation and prevention programs. Other appropriate uses may be to help provide health care for the uninsured or for the Medical Assistance program. The MMA will continue a dialogue with members on this important public health issue as we prepare for the next round of our battle against tobacco addiction.

• • • • •

Administrative Simplification Rules Released

As reported in *The Physician Advocate*, a newsletter published by the MMA, the first two sets of proposed federal rules for the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were published May 7 in the *Federal Register*.

HIPAA (also known as the Kassebaum-Kennedy Act) provides for insurance reform and administrative uniformity. It includes public, private, and self-insured health plans as well as Medicare and Medicaid. HIPAA was intended to improve the efficiency and effectiveness of the health care system by standardizing the electronic transmission of certain administrative and financial transactions. It calls upon the secretary of health and human services to adopt standards for electronic health care transactions, unique health identifiers, code sets, security, and privacy. HIPAA does not require the use of electronic transactions, but it does require all health plans, clearinghouses, and providers who choose to conduct these trans-

actions electronically to implement the standards.

Minnesota's administrative simplification act, passed in 1994 and updated in 1997, basically adopts by reference the standards that are developed and implemented under HIPAA. But Minnesota law generally requires the use of the HIPAA standards for all health care administrative transactions, paper or electronic.

National Provider Identifier

The first set of proposed rules addresses the establishment and use of the National Provider Identifier (NPI), the proposed standard for identifying all health care providers—individuals, organizations, and groups.

The NPI is an eight-character alphanumeric identifier. The identifier does not contain any embedded intelligence, such as information about the type of provider, state of residence, etc. The rationale for an "unintelligent" identifier is to allow it to "travel" with the individual provider. National Provider Identifiers would be issued by the National Provider System (NPS), which will be maintained by the Health Care Financing Administration.

Details about how providers would apply for and obtain an NPI are not yet available; given the number of providers that would need to be enumerated, a phased-in approach is likely. It is anticipated that Medicare providers would be enumerated first and would automatically be issued NPIs; therefore, most physicians would not have to apply for the identifiers. The NPI must be used in connection with electronic health care transactions, but it is likely to be used in various other ways, including by the U.S. Department of Health and Human Services to monitor fraud and abuse.

Electronic Transactions

The second set of proposed rules addresses national standards for elec-

tronic transactions, or electronic data interchange (EDI), and code sets to be used in conducting transactions. The proposed electronic standards cover the following transactions: 1) health claims or encounter information; 2) enrollment and disenrollment in a health plan; 3) eligibility for a health plan; 4) health care payment and remittance advice; 5) health plan premium payments; 6) health claim status; 7) referral certification and authorization; and 8) coordination of benefits. All of the standards, except the standard for retail pharmacy claims, come from the Accredited Standards Committee (ASC) X12N.

The proposed code sets would be required for the transactions listed above and are as follows: 1) ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification, which is used for diagnosis coding); 2) CPT-4 (Physician Current Procedural Terminology; CPT-4 is level one of the HCFA Procedure Coding System [HCPCS] and is used to code physician services); 3) Alphanumeric HCPCS (known as level 2 of HCPCS, it contains codes for medical equipment, injectable drugs, transportation services, and other services not found in CPT-4 and used in ambulatory settings); 4) CDT-2 (Current Dental Terminology is used for coding dental services); and 5) NDC (National Drug Codes are used for coding prescription drugs in pharmacy transactions).

The proposed rules would require all parties to accept the standard codes within their electronic transactions; however, payment for all services for which there are codes would not be expected. The potential for changes to the standard codes exists given the international adoption of ICD-10-CM, a new coding system under development to capture both diagnoses and procedures. The health care community has been advised to anticipate, and be ready to accommodate, a possible change within one year after final implementation of the proposed code sets.

The proposed rules also recommend a few changes to address re-

Rules continued on page 36

Copies of New E&M Framework Available

•••••To obtain a copy of the new framework for the E&M Documentation Guidelines (see Viewpoint on facing page), contact Richelle Koski at the MMA at 612/378-1875 or 800/DIAL MMA (342-5662). Comments will be accepted on the framework until the end of July, after which an E&M work group—comprised of CPT Editorial Panel members, AMA staff, and HCFA representatives—is expected to approve a new version of the guidelines for formal consideration by the Health Care Financing Administration.

MMA Helps Launch FAS Awareness Campaign

"Mothers-to-be alcohol-free" is the slogan of the public awareness campaign launched by First Lady Susan Carlson—and many representatives of the health care community—at the governor's home May 12.

Hard-hitting FAS public service announcements, posters, and brochures were unveiled at the news conference, all of which drive home the message that pregnancy and alcohol don't mix. Carlson, who saw firsthand in her work in the juvenile court system the damage that FAS can do to children and families, said she hoped the campaign would help Minnesotans affected by the disease of alcoholism.

According to Commissioner of Health Anne Barry, FAS is the leading cause of mental retardation and is currently three times as common as Down Syndrome. Barry said that each year, this preventable disease affects 800 children in Minnesota and costs the state \$45 million.

The MMA is a partner in the campaign and will distribute FAS posters and brochures to physician clinics. For more information, call Lorrie Holmgren at 612/378-1875 or 800/DIAL MMA (342-5662), or call First Call for Help at 800/KIDS 709 (543-7709). To visit the state of Minnesota's FAS Web site, go to www.fas.state.mn.us ♦♦♦♦

Join an MMA Committee

The MMA Committee on Bylaws, Committees, and Membership will soon begin the process leading to appointment of members of the MMA's standing committees for terms beginning January 1, 1999. The standing committees are: Accreditation and Continuing Medical Education; Administration and Finance; Bylaws, Committees and Membership; Communications; Ethics and Medical/Legal Affairs; Legis-

lation; Medical Practice and Planning; Minority Affairs; Professional Liability; Public Health and Preventive Medicine; and Women Physicians. To be considered for appointment to a committee, please call your component medical society or call Jane Phillip at the MMA at 612/378-1875 or 800/342-5662. She can also give you more information about the activities of each committee and about the appointment process. ♦♦♦♦

Tobacco continued from page 33

The settlement also:

- bans marketing tobacco products to children,
- eliminates tobacco advertising on billboards, buses, and taxis,
- bans tobacco merchandise giveaways,
- bans payments to the entertainment industry for displaying cigarettes in movies,
- disbands the industry's Council for Tobacco Research and prohibits the industry from making claims about the health consequences of tobacco,
- prohibits the industry from challenging state tobacco laws in court, and

- calls on the industry to maintain public document depositories for 10 years.

McCain Bill Debated in Congress

At the federal level, lawmakers were debating various amendments to the tobacco bill sponsored by Sen. John McCain, R-Arizona, at presstime. The legislation would increase the federal excise tax on cigarettes by \$1.10 per pack, impose penalties of up to \$4 billion a year if the industry doesn't meet targets for reducing smoking by kids and teens, and give authority to the Food and Drug Administration to regulate tobacco. ♦♦♦♦

Rules continued from page 35

dundancy among the code sets. For one, dental codes would be eliminated from HCPCS, and the American Dental Association (ADA) would become the sole source for dental codes. Also, "J" codes (drug codes) would be deleted from alphanumeric HCPCS, and the NDC codes would become the standard. This could mean a change for providers, who would now be required to incorporate the 11-digit NDC codes for drug-coding transactions. Finally, level 3 HCPCS codes, currently established locally by health insurers to address local needs and gaps in the national system, would be replaced with a national process for the establishment of national temporary codes.

The MMA, through the Administrative Uniformity Committee and in a review and comment process established by the Minnesota Health Data Institute/Minnesota Center for Healthcare EDI, will assess the impact of the proposed rules on Minnesota physicians. Comments on the rules will be accepted until July 6. The effective compliance date is 24 months after publication of the final rules (36 months for small health plans). ♦♦♦♦

The Monitor

JUNE 1998

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THE QUESTIONS

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Why are younger people now considering it?

Why are business owners looking into long term care insurance?

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THE FACTS

43 percent of those over 65 will spend some time in a nursing home.*

The first of the baby boomers are turning 50, while at the same time their parents are aging into their 70's and 80's.

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* New England Journal of Medicine, February 1991

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Manuscripts

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A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

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Title and Authors' Names

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2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
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Managed Care in Rural Minnesota

Family Physicians' Attitudes and Perceptions

Kevin Wentworth, M.S. II, Joshua Crabtree, M.S. II, Jay Mitchell, M.S. II, and James Boulger, Ph.D.

ABSTRACT

Prepaid managed care medicine has become dominant in urban Minnesota and is making its way into the rural setting. This study assesses the attitudes of rural family practice physicians in Minnesota toward managed care. A survey, consisting primarily of five-point Likert scale statements, was mailed to 798 rural Minnesota family practice physicians, with a response rate of 35% (281 respondents). We tabulated overall responses and made comparisons based on practice characteristics and years in practice. Twenty physicians participated in a follow-up telephone interview. We also conducted telephone interviews with 10 representatives from managed care organizations.

Both positive and negative attitudes toward managed care emerged. Two-thirds of respondents did not feel that their time with patients was diminished under managed care. However, 67% of respondents felt that managed care organizations had failed to incorporate rural patients' specific needs into their policies. Only 7% of respondents felt that managed care organizations adequately explained their benefits packages to enrollees. Rural family practitioners' apparent disillusionment with current managed care models merits the attention of those concerned with medical care in rural areas.

Health care costs continue to rise in Minnesota and the nation. In response, health care financing has moved toward a prepaid, managed care model, which has affected health care economics and delivery. Financing methods include traditional fee-for-service arrangements as well as health maintenance organizations (HMOs). Some observers consider HMOs the most comprehensive form of medical cost management, since these plans require patients to obtain all care through the plan or pay for costs directly.¹

"Managed care" is not a new concept; labor and industry leaders have advocated some form of managed care for more than 50 years. Even earlier, during the 1800s, some physicians contracted with plantation owners to provide medical care for slaves for a fixed annual fee per patient.² "Modern" managed care can be traced directly to Sidney Garfield, M.D., who, in the early 1900s, contracted with the Kaiser Construction Group to provide health care to its employees for \$1.50 per month per employee.³⁻⁵ In the early 1930s, the Federal Committee on Costs of Medical Care recommended a prepaid health plan for all Americans. Organized medicine, however, did not embrace the idea of prepaid health care and strongly opposed control by large employers and fixed salaries for physicians.⁴ The first fully operational HMO was established in Two Harbors, Minnesota, under the auspices of the mining, railway, and timber industries.⁶ Still, the managed care movement grew quite slowly for decades.

More recently, managed care has dominated the health care landscape, particularly in densely populated urban areas. In the Twin Cities, enrollment in HMOs rose from 100,000 in

1975 to 1.2 million in 1987.⁷ It wasn't until 1993 that the managed care market began to move into rural Minnesota, with changes to MinnesotaCare legislation and the creation of integrated service networks (ISNs). The expansion into greater Minnesota continued when community integrated service networks (CISNs) were proposed in 1994 as another way for rural providers to create locally controlled HMOs/ISNs.

Despite these efforts, managed care has not taken hold quickly in rural Minnesota—by January 1998, only three CISNs had been licensed by the Department of Health—and many rural family physicians have not gained extensive experience with managed care.⁷ There may be many reasons for slow development of rural managed care organizations, including physician resistance. Physicians who are "new" to the system must be educated about prepayment and solicited to participate.⁵ Resistance may also be attributed to a lack of community understanding, the sparsity and age of the rural population, and the absence of large employers.

Christianson and Moscovice have described factors that are important for managed care to succeed in the rural health care market (e.g., identification of specific rural needs, good medical specialty distribution and access, utilization management, physician recruitment and retention, solid physician-patient relationships, and customer education).⁸

This study describes the attitudes and perceptions of rural family practitioners, who are key to the success of managed care in rural areas.

The evolution of "managed care" has resulted in a variety of health care products, which makes defining the term difficult. We chose to adopt the

Minnesota Department of Health's published definition: "Managed care is a way to deliver health care services in a high-quality, cost-effective manner."⁹ The definition also includes the following characteristics: an emphasis on primary and preventive care, monitoring of quality assurance and health outcomes, utilization review, prior authorization, and provider risk-sharing.

METHODS

Our study sample consisted of 793 active, licensed family practice physicians in greater Minnesota. We obtained the sample from the 1995 Health Professions Database compiled by the Minnesota Department of Health, Office of Rural Health and Primary Care. Family practitioners from the seven-county metro area (Minneapolis/St. Paul), Duluth, St. Cloud, and Rochester were excluded. Each physician in the sample received a cover letter and survey in July 1996, followed by a reminder card two weeks later.

The survey contained questions about years in practice, practice setting, and experience with managed care; in addition, a series of five-point Likert scale statements assessed physicians' attitudes concerning the implementation of managed care in rural Minnesota, particularly within their own practices. The statements dealt with respondents' understanding of managed care, physician recruitment and retention, referral systems, managed care organization policy formation, reimbursement for preventive services, and managed care's response to rural family practitioners' needs. We asked physicians to rate managed care's impact on the quality of and access to several specific services, including telemedicine, mobile imaging, and information management. Physicians also responded to the open-ended question, "What, specifically, could managed care organizations do to help you deliver quality health care?" Finally, physicians willing to participate in a follow-up phone interview were asked to describe positive aspects of managed care in their practice, health care delivery issues they felt were unique to rural practice, and how

managed care organizations (MCOs) could better address those issues.

In addition, 10 organizations that provide managed care in greater Minnesota (see list, page 44) were contacted by telephone. An initial letter asked the organization's president/CEO or other representative to be prepared to answer the following questions:

1. What, specifically, can your organization do to help rural family practice physicians deliver quality health care?

2. What are some of the obstacles to providing managed care in rural areas?

3. What are some of the opportunities for your organization that are specific to the rural environment?

To analyze the results, we tabulated frequencies and percentages and used Student's *t*-tests to compare group responses. We analyzed the Likert statements using Student's *t*-tests ($\alpha = .05$), contrasting the responses of family practitioners in solo practice, single-specialty practice, and multispecialty practice. We made a similar comparison for physicians with 10 or fewer practice years versus those with more than 10 practice years.

RESULTS

Of the 798 surveys mailed to rural family practitioners, 281 (35.2%) were returned. The respondents were from 63% of Minnesota's rural communities that received surveys. Additionally, 20 respondents participated in telephone interviews.

The mean number of years in practice for respondents was 15.6 years. Almost 74% of responding physicians reported having a managed care contract; they have had their contracts for an average of 5.8 years. Respondents also reported that nearly one-quarter (24.8%) of their patients have managed care coverage. The Likert scale statements about respondents' attitudes and perceptions toward managed care in rural Minnesota are listed in Table 1.

Overall, only 5.3% of respondents believed that rural family practitioners are adequately involved in managed care policy development, and relatively few physicians (15.8%)

felt confident in their overall knowledge of managed care contracts. Furthermore, only 10% believed managed care organizations were sensitive to the needs of rural family practitioners. Approximately half of the respondents (48.4%) disagreed that MCOs adequately reimburse physicians for providing preventive care. One out of five respondents (19.7%) agreed that managed care enhances the role of the family practitioner as patient advocate (see Table 1).

Approximately as many respondents agreed as disagreed that managed care decreases the amount of time physicians spend with patients. Similarly, responses were divided on whether managed care cost-control measures have resulted in a diminished quality of health care. Thirty-four percent believed that cost-control measures have been detrimental to health care quality, while 25.3% disagreed. Thirty-one percent believed that less time is spent with patients because of managed care, while 28% reported no decrease. In addition, 49% of respondents believed that managed care organizations have assumed unreasonable control of patient care.

Fifty-four percent of responding physicians agreed that a patient's health plan has a large impact on care received. Very few respondents (7%) believed that MCOs properly explain benefits packages to their enrollees, and only 4.6% agreed that MCOs do an adequate job of incorporating rural patients' needs into their policies. Respondents overwhelmingly agreed that MCOs have not increased access to and quality of chemical dependency and mental health services (see Table 1).

Comparisons among the solo practice, single-specialty practice, and multispecialty practice respondents revealed a number of significant differences (see Table 2), as did comparisons based on years in practice (see Table 3). Generally, solo practitioners' responses concerning managed care were more negative than those of single or multispecialty practitioners.

DISCUSSION

The majority of respondents report

Table 1

*Mean responses to the Likert-scale statements**(1-Strongly Disagree, 2-Disagree, 3-Neutral, 4-Agree, 5-Strongly Agree)*

Statement	Mean $\pm$ S.D.	Statement	Mean $\pm$ S.D.
Managed care adequately reimburses physicians for the provision of preventive care.	2.42 $\pm$ 1.02	My professional staff (PA, NP, RN) see managed care as a positive influence on health care delivery.	2.50 $\pm$ 0.79
Managed care organization cost-control measures have resulted in a diminished quality of health care.	3.14 $\pm$ 1.02	Managed care has resulted in an increase in the number of patients I admit to the hospital.	2.16 $\pm$ 0.79
I feel rural family practitioners are adequately involved in managed care policy development.	1.97 $\pm$ 0.85	Managed care decreases the amount of time a physician gets to spend with each patient.	3.05 $\pm$ 1.02
Managed care organizations properly explain benefits packages to their enrollees.	1.96 $\pm$ 0.89	When I refer within my managed care system, I remain well-informed of my patient's care.	3.20 $\pm$ 0.89
Managed care enhances the role of the family practitioner as patient advocate.	2.58 $\pm$ 1.09	Managed care does little to ensure physician retention in my service area.	3.86 $\pm$ 0.95
Prior authorization rarely impedes the delivery of health care.	2.51 $\pm$ 1.08	Managed care has assumed unreasonable control of patient care.	3.49 $\pm$ 1.10
Patients who switch to managed care plans more appropriately utilize health care services.	2.63 $\pm$ 0.96	Managed care organizations incorporate the specific needs of rural patient populations into policy formation.	2.00 $\pm$ 0.88
Managed care organizations properly inform their physicians about the organizations' health care policy and procedures.	2.53 $\pm$ 0.90	Managed care allows family practitioners to deliver quality health care in a cost-effective manner.	2.93 $\pm$ 0.94
Managed care organizations provide rural physicians higher reimbursement than urban physicians.	1.85 $\pm$ 0.89	Preventive medicine can be practiced more appropriately within a managed care system.	2.90 $\pm$ 1.01
In your practice, managed care has decreased the number of referrals to other specialists.	2.63 $\pm$ 0.91	Managed care has increased the access to and quality of the following services: (1=no increase at all, 5=an extreme increase)	
I feel confident in my overall knowledge of managed care contracts.	2.58 $\pm$ 0.98	Telemedicine access quality	1.88 $\pm$ 1.16 1.86 $\pm$ 1.04
My access to consultations has improved under managed care contracts.	2.30 $\pm$ 0.81	Mobile imaging access quality	1.80 $\pm$ 1.05 1.86 $\pm$ 1.07
Managed care plays a large role in recruiting physicians in my practice.	1.95 $\pm$ 1.06	Information management access quality	2.15 $\pm$ 1.08 2.08 $\pm$ 1.03
Managed care is sensitive to meeting the needs of family practitioners.	2.42 $\pm$ 0.88	Utilization review access quality	2.77 $\pm$ 1.18 2.26 $\pm$ 1.11
A patient's health plan has a large impact on the care that patient receives.	3.52 $\pm$ 1.15	Chemical dependency treatment access quality	1.57 $\pm$ 0.85 1.64 $\pm$ 0.90
Managed care has decreased my use of nursing homes in patient care.	2.29 $\pm$ 0.75	Mental health services access quality	1.61 $\pm$ 0.89 1.63 $\pm$ 0.89
		Consolidation of access administrative services quality	2.06 $\pm$ 1.11 1.90 $\pm$ 1.01

experience with managed care but do not feel confident in their knowledge of managed care. When asked about managed care organizations, one physician simply stated, "Too many, too confusing." In addition, the physicians report that their professional staffs are not convinced that managed care has a positive influence on health care delivery. Much of this consternation seems to stem from a lack of effective communication. As seen in both the survey results and comments, physicians do not believe that MCOs are adequately explaining their policies to enrollees or physicians. Twenty-one percent of the comments address the need for improving patient and/or physician education regarding managed care policy. This lack of understanding leads to conflicts with patients as physicians are forced to explain the realities of utilization management and its impact on patient care. One phy-

sician states, for example, that managed care plans should "better educate patients regarding the need to limit frivolous care and demands for high-tech and unnecessary tests instead of saying, 'It's up to your doctor.'" Several of the managed care representatives interviewed recognized this complaint and said that their organizations consider patient and physician education a priority.

Despite these frustrations, the majority of physicians did not report that managed care decreases their time with patients or reduces the cost-effectiveness of their care. When asked how MCOs can improve health care delivery, one physician wrote, "My HMO already does a good job at this." Other respondents, however, expressed concern about utilization management and its potential effects on patients' interests. One physician stated: "Let the physician do their job—eliminate microman-

agement and specifically eliminate the growing number of 'prior authorization' constraints—this wastes our time, patient time and is designed to be another hoop insurance companies hope physicians won't have the time or ambition to jump through, thus the procedure or medication doesn't get ordered and money is saved!"

Physicians also reported that patients who switch to managed care plans do not use health care services more appropriately. This concern is an acknowledged obstacle for managed care organizations attempting to move into rural Minnesota. One managed care representative said that frequent—and often polarized—media coverage engenders a generalized fear of managed care that is unfounded in Minnesota. Another representative argued that provider fear is unfounded and pointed out that traditional fee-for-service models have

Table 2

Significant differences between solo vs. single practice and solo vs. multispecialty practice (significant at $p \leq 0.05$)

(1-Strongly Disagree, 2-Disagree, 3-Neutral, 4-Agree, 5-Strongly Agree)

Statement	Solo practice	Single practice	Multispecialty
Managed care enhances the role of the family practitioner as patient advocate.	1.63	2.65	2.67
Patients who switch to managed care plans more appropriately utilize health care services.	1.94	2.71	2.68
Managed care organization cost-control measures have resulted in a diminished quality of health care.	4.06	3.13	2.98
Managed care allows family practitioners to deliver quality health care in a cost-effective manner.	2.18	2.93	3.05
Preventive medicine can be practiced more appropriately within a managed care system.	2.06	2.88	3.08
Managed care has increased the quality of mobile imaging.	1.08	1.79	1.98
Managed care has increased the quality of information management.	1.15	2.07	2.18
Managed care has increased the access to utilization review.	1.88	2.95	2.76
Managed care has increased the quality of consolidation of administrative services.	1.08	1.95	1.92
Managed care has increased the quality of utilization review.	1.15	2.38	2.30

not proven more cost-effective. Still, whether these fears are warranted or not, they must be addressed if managed care is to be successfully implemented in rural Minnesota. Nearly all managed care representatives emphasized their desire to assist providers in offering cost-effective, quality health care.

Managed care representatives interviewed said they believe their organizations can assure rural patients access to urban hospitals and specialty care. They also said they hope to introduce improved technology and information management to the rural medical environment. One health plan has six "creative partnerships" in which the plan leases management services to rural physician groups, allowing the physicians to focus on patient care. However, physician respondents in this study report no change in the number of referrals, no improved access to consultations, and no increase in access to or quality of numerous services. In written comments, the physicians complain that managed care referral contracts are established "with complete disregard to the [previous] referral patterns in our area." Respondents emphasized the need to improve access to mental health and chemical dependency services, in particular. When referring within their MCO, over one-third of respondents said that they remain well informed of their patients' care.

Several managed care representatives said their organizations assist with and improve rural physician recruitment and retention. The physicians reported, however, that managed care has done little in these areas. One physician suggested managed care organizations should "recruit staff from rural areas, recognize local input, and increase reliance on local practitioners."

The result of our survey and telephone interviews indicate that rural physicians are concerned that managed care does not recognize the unique issues involved in rural health care. They do not believe that MCOs incorporate rural patients' needs into policy development. And they do not believe that rural family practitioners are adequately involved in poli-

Table 3		
<i>Significant differences between physicians with ≤ 10 practice years vs. >10 practice years (significant at $p \leq 0.05$)</i>		
Statement	≤ 10 years	>10 years
Managed care plays a large role in recruiting physicians in my practice.	2.12	1.84
Managed care enhances the role of the family practitioner as patient advocate.	2.82	2.44
Managed care does little to ensure physician retention in my service area.	3.70	3.98
Managed care organizations provide rural physicians higher reimbursement than urban physicians.	2.02	1.70
Managed care has resulted in an increase in the number of patients I admit to the hospital.	2.31	2.06
Managed care is sensitive to meeting the needs of family practitioners.	2.59	2.29
Managed care has increased the quality of mental health services.	1.48	1.74

cy development or that MCOs are sensitive to their needs.

Respondents were also sensitive to perceived discrepancies in reimbursement between themselves and their urban counterparts and mentioned the lack of reimbursement for time spent "managing" care—seeking prior authorization, justifying consults, finding "in-network" consultations, etc." Several managed care representatives acknowledged the unique requirements of rural medicine and the importance of addressing those issues. The representatives also described the obstacles they face in rural expansion, including the difficulty of breaking into rural markets long dominated by fee-for-service and major medical insurance and dealing with reduced federal reimbursement for rural care. Finally, as the managed care representatives expressed, and as this study shows, managed care plans have yet to conciliate a skeptical population of rural family practice physicians in Minnesota.

CONCLUSION

Rural physicians have identified needs

specific to their practices, many of which MCOs claim to meet. This suggests that a working relationship between family practitioners and MCOs should be complementary. However, this study found that family physicians feel uninformed about managed care and uncertain as to whether or not it increases the quality of rural health care delivery. This discrepancy leads to further questions for review:

1. What is the best way for managed care organizations to provide and share information with physicians and patients in rural areas?

2. How can the physician's role in managed care organizations avoid conflict with the physician's role as patient advocate?

We suggest that neither MCOs nor rural family practitioners can resolve this conflict alone. As one physician states, "Managed care is not the source of all problems—M.D.s and patients have tried to avoid wrestling with monetary realities too long; everyone wants lots of service at no cost." Until managed care organizations and rural physicians effectively

Managed Care Organizations Interviewed

- Allina Health System, Minneapolis
- Blue Cross and Blue Shield of Minnesota, St. Paul
- Central Minnesota Group Health Plan, St. Cloud
- First Plan of Minnesota, Two Harbors
- HealthPartners, Minneapolis
- Mayo Health Plan, Rochester
- New Pioneer Health Plan CIGN, Willmar
- Preferred One, Minneapolis
- Southwest Minnesota Health Cooperative, Willmar
- Ucare Minnesota, St. Paul

align their respective efforts—or at least educate one another on their needs and goals—it appears that physicians' uncertainty and frustration will persist. **MM**

All authors are at the University of Minnesota—Duluth School of Medicine. Kevin Wentworth, Joshua Crabtree, and Jay Mitchell were second-year medical students at the time of research. James Boulger is associate professor of family medicine and behavioral sciences.

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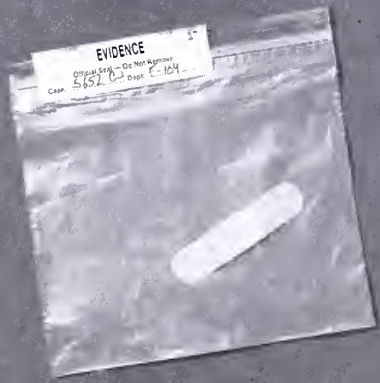


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Compliance ... or Else!

With the federal government on "fraud alert," physicians and hospitals are under the spotlight of suspicion.

William R. Fifer, M.D., F.A.C.P.

It was early fall of 1997 when the concept of "corporate compliance" entered my brain. I was asked to present a segment of a conference for one of my longtime hospital clients at its annual retreat. The evening before, I had dinner with three members of the hospital's executive staff, along with my co-presenter. Usually I am called upon to present in the area of medical staff relations, such as the latest style in quality improvement, or new credentialing issues. I thought it odd that my fellow faculty member was an esteemed health care lawyer, and wondered how our two presentations would fit together.

Three hospital executives were at the dinner party: the chief operating officer, the director of managed care operations, and the "corporate compliance officer." Since I had never encountered one of the last species, I asked him what he did at the hospital. I learned about a whole new area of hospital-payer distrust, called corporate compliance. I was to learn much more about it at the following day's seminar.

My lawyer colleague explained that the key element in a hospital's corporate compliance policy was to establish standards and procedures to "stay out of jail" should the hospital run afoul of government statutes and regulations pertaining to contracts, conflicts of interest, or the many provisions of federal antitrust law. As my colleague proceeded with his talk, he terrified the audience by describing illegal physician recruitment tactics, anti-kick-back provisions, and false claims. He vividly detailed the financial consequences of being caught with false claims, evoking a notorious *qui tam* case in which the whistleblowers were awarded \$22 million.

He then outlined the federal government's expectations for compliance with this new set of regulations and

described the extensive training and education program a hospital must establish to assure accurate billing and avoid "upcoding." As I looked about the roomful of people, I saw the compliance officer sagging under the weight of his new responsibilities, the executive team deciding that compliance was the necessary price to pay for staying out of jail, and the hospital trustees wondering how their duties ever became so complex and so very heavy. Trustees view their job as one of setting policies to promote the general health of the community. They wondered what had caused the federal payer to become so angry and dictatorial. Couldn't they be trusted to behave honestly and with integrity? Where did all this distrust come from? Were doctors and hospitals assumed to be guilty of dishonest and fraudulent behavior in their care of patients until proven innocent?

Where did all this distrust come from?
Were doctors and hospitals assumed to be guilty of dishonest and fraudulent behavior in their care of patients until proven innocent?

Federal Authorities on 'Fraud Alert'

Contemporaneously with this hospital retreat, we had all been reading about the charges that Columbia/HCA had deceived regulators on several fronts. You may recall the pictures of federal agents seizing truckloads of documents from more than 50 Columbia/HCA facilities in seven states. Could Columbia/HCA be blamed for the torrent of abuse being visited on innocent hospitals and physicians? The federal government seems to have decided that detecting and prosecuting health care fraud and abuse are a law enforcement priority, second only to fighting violent crime. According to *AHA News*, FBI fraud investigations more than tripled from FY 1992 to FY 1996, jumping from 657 to 2,200 cases.¹ Attorney General Janet Reno called this "significant progress against unscrupulous health care providers." The Office

of Inspector General (OIG) of the U.S. Department of Health and Human Services is now regularly issuing special "fraud alerts." The feds have a \$5 million coffer provided by the 1996 Health Insurance Portability and Accountability Act and expect to recoup over \$56 billion in savings to the Medicare plan.

"All hospitals should establish compliance programs," the AHA says.² All hospitals? (The inspector general's office has targeted 4,700 of the nation's 6,300 hospitals for suspicion of abuse.) Can none of us be trusted to deal fairly and honestly with our biggest customer, the Medicare program? Some authors compare the situation to that of the Defense Department in 1983. As a result of compliance programs, now you seldom read about million-dollar toilets.

Are these early fishing expeditions paying off? The government is reviewing Medicare and Medicaid outpatient billings at six Minnesota hospitals suspected of "unbundling" laboratory tests. Baptist Medical Center in Kansas City, Missouri, accused of kickbacks (in the form of consulting fees paid to physicians in exchange for Medicare patient referrals), paid a \$17.5 million fine. A group practice of teaching physicians at the University of Virginia has agreed to pay \$8.6 million for inadequate documentation of services rendered to Medicare patients. The OIG is implementing a PATH (Physicians at Teaching Hospitals) initiative aimed at academic health centers; DHHS suspects that senior doctors received Medicare Part B payments for services actually performed by residents, who are already paid by Medicare Part A. One result to date is a \$30 million settlement paid by the University of Pennsylvania for documentation and coding problems attributed to residents and students. The Jefferson Faculty Foundation settled for \$12 million.

The False Claims Act, federal legislation targeting government contractors that submit false claims for goods and services, has been used to combat fraud in a number of industries, most notably defense and health care. The act carries criminal and civil penalties, including triple damages and fines between \$5,000 and \$10,000 per false claim. The latest False Claims Act probe is looking at possible upcoding of pneumonia cases. Simple (viral) pneumonia is the second largest DRG, in terms of

discharges and payout, among inpatient codes. The average Medicare payment for simple pneumonia is \$4,535; the total payment in 1995 was over \$2 billion. Bacterial pneumonia was also in the top 10, with an average Medicare payment of \$7,210. Billings are based on the attending physician's diagnosis on the face sheet, and the documentation is not always clear. Crozer-Keystone Health System paid a \$664,500 fine for im-

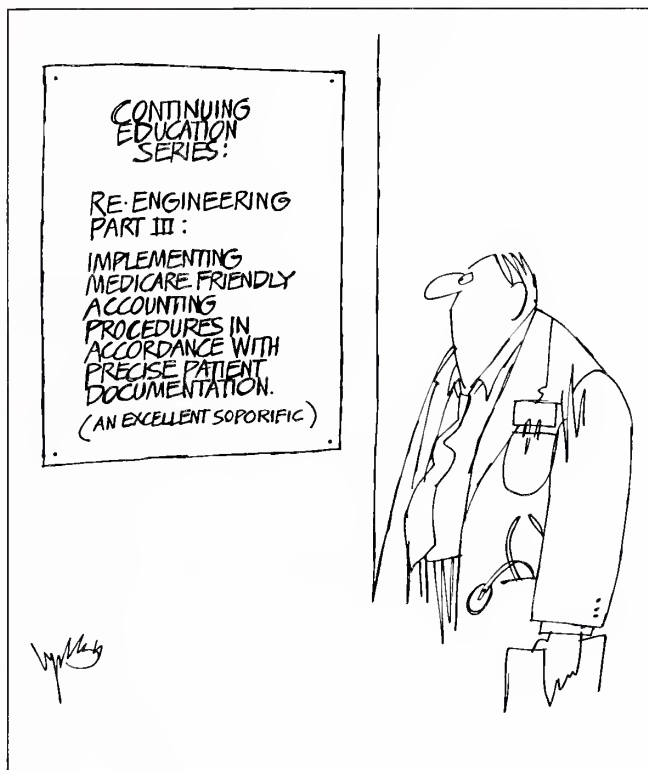
proper documentation of pneumonia and agreed to provide additional training for their billing coders. Insufficient or absent documentation is responsible for almost half (46 percent) of the improper payments. Insufficient evidence of medical necessity is the next biggest cause (37 percent) of improper Medicare payments, according to Congress; incorrect coding ranks third, accounting for 8.5 percent of the errors.

Spotlight on Physicians

Now the spotlight is turning to the doctor's office: individual physicians may be subject to substantial fines, criminal prosecution, and expulsion from federal programs. Fraudulent and abusive health care pro-

viders were excluded from Medicare at a rate of nine per day for the first 11 months of 1997, and in the past 10 years, about 1 percent of the estimated 1 million Medicare service providers have been sanctioned. What is the issue here? Are individual physicians intentionally lying about the services they provide to Medicare patients? Liability under the false claim law does not require intent. Again, inadequate provider documentation is a common culprit.

A key issue for physicians is the evaluation and management (E&M) guidelines. These guidelines are unbelievably detailed. The level of E&M service a doctor chooses is based on four types of history taking: problem-focused, expanded problem-focused, detailed, and comprehensive. The patient history depends on the nature of the presenting problems but must include some or all of the following: the chief complaint; the history of the present illness (HPI); review of systems; and the past, family, and/or social history. For a "brief" HPI, an E&M auditor will expect to find one to three elements in your documentation; for an extended HPI, you'll need to show at least four elements.



Documenting the complexity of medical decision-making is mind-boggling. In cases with a minimal number of diagnoses or management options, reviewing the data is relatively straightforward. However, if a case presents multiple possible diagnoses or management options, the decision is said to be of "high complexity," and HCFA expects to find extensive documentation.

Fortunately, HCFA backed off plans to implement the E&M guidelines this summer and may delay for as long as a year, thanks to vigorous opposition from the American Medical Association, the Minnesota Medical Association, and others. The AMA and HCFA are designing a new framework. The MMA will gather physician input on the guidelines until August, when the ideas will be forwarded to the AMA working group.

Does Every Hospital Need a Compliance Officer?

What constitutes a good "compliance officer"? To quote Philip Dunn, "They are part cop, part priest, part confidante, and part snitch."³ Compliance officers are a new and highly paid member of the executive team with at least some background in ethics, billing, auditing, and law. Chris Serb describes the compliance officer as something of a "shuttle diplomat" who keeps up with regulations, educates the staff, and gathers information from all departments.⁴ Sean Martin cites the seven elements of a compliance plan recommended by the American Medical Association,⁵ which include routine training and education, auditing and monitoring claims development and submission, a "hot line" for reporting suspected violations, and appropriate corrective action programs to resolve problems.

The federal government seems to believe there is so much fraud and abuse out there that wholesale auditing of doctors' office records and hospital financial operations is justified. In large part, I hope they are wrong. In attacking academic health centers, they are impugning the basic moral code of teaching and learning in a profession of great integrity. I can recall no medical school class that taught us to lie or cheat or steal. Doctors and hospitals have a centuries' old code of ethics and a moral obligation to care for the sick and wounded. The public holds doctors and hospitals in the highest esteem—they trust us to act in their best interest. If a minority of our company acts dishonestly, it is up to the rest of us to drum them out of the corps. If they besmirch our integrity, we are being tarred by their brush. It is surely an overreaction to suggest that every hospital needs a compliance officer. Either the regulations have become too complex, or the taint of one system has poisoned the whole well of health care. MM

William Fifer is an author, lecturer, and consultant to hospitals and professional associations nationwide and a core faculty member in the Estes Park Institute Conferences. He formerly worked for 15 years as an internist in

a multispecialty group practice. He is a member of the adjunct faculty at the Center for Health and Medical Affairs at the University of St. Thomas and serves on the advisory board of the HealthEast Healing Center in St. Paul.

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Fraud Investigations: The Heat Is On

Physicians beware: The federal government is clamping down on health care fraud, and even innocent mistakes can mean trouble for your practice.

John W. Lundquist, J.D., and David M. Glaser, J.D.

The wave of health care investigations that began several years ago is rapidly gaining momentum. New federal legislation is making health care a highly regulated arena, with more than \$100 million spent annually on fraud and abuse enforcement. Medicare and third-party payers are scrutinizing providers carefully. Physicians are most commonly being investigated for overbilling Medicare. The new Medicare carrier for Minnesota, United HealthCare, appears to be adding turbulence to the already troubled waters. Physicians throughout the state are receiving requests for medical records as the carrier tries to recover overpayments. In many cases throughout the country, alleged overpayments have been in the hundreds of thousands of dollars, and court settlements in a handful of cases have been in the millions.

It comes as a shock to many providers that you can go to jail or face staggering penalties—even if you think you're complying with the law. This can occur if you know that a bill from your office is false, if you remain deliberately ignorant about how billing is handled, or if the government can prove that billing has been done with "reckless disregard of truth or falsity." The government often alleges that any billing mistake demonstrates "reckless disregard for the law." In fact, in some cases, the government will try to recover an overpayment even if you acted on the advice of your Medicare carrier.

Laws guarding against health care fraud are nothing new. Federal criminal statutes have been in effect for some time. Bolstering these statutes are six new laws that took effect in early 1997 under the Health Insurance Portability and Accountability Act of 1996, which was voted into law to protect consumer access to insurance coverage and to further prevent fraudulent claims. In addition, there's a cadre of state and civil laws prohibiting health care fraud.

The teeth in all these laws—both old and new—got sharper when the 1996 act established the Medicare Fraud and Abuse Control Program, which is administered by the Office of Inspector General of the Department of Health and Human Services and the Department of Justice. The biggest change is an increase in the funding for agents to investigate health care providers. For example, the number of FBI agents working exclusively on health care cases has more than doubled in the last few years and is slated to double again by 2001. Moreover, FBI agents had been limited to investigating criminal allegations. The new laws permit agents to investigate civil charges. The purpose of the control program is to coordinate federal, state, and local enforcement programs, conduct investigations, and enforce sanctions. The program also is responsible for establishing a national databank and for providing industry guidance, including advisory opinions, safe harbor regulations, and fraud alerts.

HEALTH CARE FRAUD PENALTIES CAN BE COSTLY

Recent prosecutions have resulted in huge fines, penalties, and restitution. The government obtained large recoveries in *United States v. First American Home Health Care* (\$215 million), *United States v. SmithKline* (\$325 million), and *United States v. Thomas Jefferson University* (\$12 million). Closer to home, the federal government obtained \$161 million in *United States v. Caremark* (Caremark formerly offered home-infusion services in Minnesota and distributed drugs to physicians under a financial arrangement the government concluded was illegal). The government announced in January that it had recovered nearly \$1 billion in Medicare fines and settlements in 1997 alone. While physicians often think that only corporations face such substantial penalties, physicians have also been investigated. The goal of the Medicare Fraud and Abuse Control Program is to become self-funding through such recoveries.

OIG INVESTIGATION PRIORITIES FOR 1998

The Office of Inspector General (OIG) has issued its workplan for 1998. It identifies many priority-level enforcement areas. One OIG project, Incontinence Care Fraud, is on the lookout for suppliers who bill for "female external urinary collection devices" but provide nursing home beneficia-

ries with diapers, which are not covered under Medicare. The OIG has initiated the Pneumonia DRG Up-coding Project to identify hospitals that falsely claim the diagnosis of bacterial pneumonia for viral pneumonia. Project "Bad Bundle" seeks to identify hospitals that unbundle automated blood chemistry tests and then bill for each analysis separately. Managed care will become a government target soon.

The most common problem leading to an audit is poor documentation. Medicare often takes the position that "if it is not written, it wasn't done." As a result, Medicare regularly seeks refunds on any service for which the documentation doesn't comply with Evaluation and Management Documentation Guidelines. Although implementation of the new E&M guidelines has been postponed indefinitely, HCFA continues to audit using the guidelines promulgated in 1995. Physicians with insufficient documentation run the risk of having their service improperly and unfairly denied.

Medicare also has announced that it intends to enforce some billing rules it has ignored in the past. For example, Medicare is now aggressively enforcing reassignment rules, which state that only the physician who performed a service may bill for that service unless specific exceptions apply. This is one reason that it's becoming more difficult for physicians to apply for Medicare provider numbers. Rules governing physician supervision of assistants, nurse practitioners, and nurses also are being more intensely reviewed. For a bill generated under a physician's billing number to be valid, a member of the doctor's group must be physically present in the office suite to supervise the staff providing the service, and the physician must be regularly involved in the patient's care.

Another new area of investigation is physician certification for home health, durable medical equipment, and related services. The government believes that in many cases patients are receiving these services unnecessarily, and HCFA officials have indi-

cated that they intend to investigate physician certification of medical necessity.

The U.S. Attorney's Office for the District of Minnesota has two prosecutors dedicated to criminal health care fraud, and another who focuses on civil false claims and recoveries and overpayments. This office was responsible for the prosecutions against Caremark, Inc., and John Najarian, M.D. This office has made it clear that investigating health care fraud is a priority in Minnesota.

The OIG's National Exclusions Project requires that entities and individuals who engaged in specified misconduct be excluded from participation in all federal health care programs. The Exclusion Data Transfer service of the OIG will provide current information to government agencies about individuals and companies that have been excluded from Medicare and Medicaid programs. The inspector general is committed to working with state Medicaid programs to strengthen and enforce exclusion actions. In 1997, more than 2,700 individuals and entities were excluded from participation in state and federal health care programs.

Fraud alerts will be employed to inform the health care industry of practices that the OIG determines are "highly suspect." The inspector general will implement new exclusion and civil monetary penalties recommended by the 1996 act. Lastly, the office of Evaluations and Inspections will continue to review corporate integrity plans developed by providers who have been involved in a settlement process. Not only has the government announced that it intends to step up enforcement of both the criminal and civil laws pertaining to health care fraud, but the U.S. Supreme Court also recently made it easier for the government to simultaneously pursue both civil and criminal tracks in these cases. The court ruled in December 1997 that the Double Jeopardy Clause does not prevent prosecutors from seeking both civil monetary penalties and restitution while at the same time punishing providers under criminal statutes.

HOW TO HANDLE AN INVESTIGATION

If a government agency indicates that your office is the subject of an investigation, scrupulously follow this checklist to avoid further legal entanglements:

1. If government agents present a search warrant, obtain a copy and refrain from discussing the situation with them.

2. CALL YOUR LAWYER IMMEDIATELY.

3. Verify the agents' credentials by getting a business card or copy of an ID for each individual involved in the investigation.

4. Don't panic. Stick to your checklist.

5. An agent's strongest weapon is your fear or false confidence. Either can prompt you to talk. Although silence can be awkward, don't give in to the temptation to fill an uncomfortable silence. Take time to work with your attorney on a communication strategy that makes sense given the particulars of your case.

6. It's important to evaluate the facts before responding to a request for information. You may be able to protect some information by invoking a privilege. Once privileged information is released, it's likely that the privilege has been lost. A government agent can't require anyone to submit to any type of interview. However, agents may contact employees at home because they may be more comfortable there and feel less pressure from an employer. An employer cannot forbid employees from speaking with an agent—such an edict may constitute obstruction of justice. However, employers can and should inform employees of their rights via a memo from their attorney. Basically, employees can choose whether or not to speak to an agent; if they do, they may have an attorney present; employees should be instructed to tell the truth—lying to a government agent is a crime; no one should ever attempt to destroy documents or hide evidence during an investigation.

7. When an investigation begins, don't be falsely soothed by the idea that it's all a misunderstanding that can be cleared up with a quick meeting.

CONCLUSION

Health care providers and their attorneys must stay abreast of changes in both national and local enforcement legislation and trends. The laws change regularly, and the line between an innocent mistake and fraud is not always clear. Your best protection is to become familiar with the laws, abide by them, and stick to your checklist should an investigation ever occur in your organization. **MM**

John Lundquist, who participated in the defense of several cases mentioned in this article, has 20 years of experience in white-collar criminal investigations, trials, and appeals in state and federal courts. He is an attorney with Fredrikson & Byron, P.A., in Minneapolis, where he chairs the firm's Medicare Fraud and Compliance Group. David Glaser is a member of Fredrikson & Byron's Health Law Group, where he practices in the areas of reimbursement and regulatory issues.

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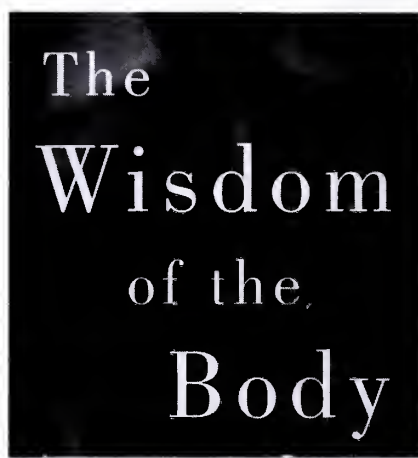
Dr. Sherwin Nuland's book "The Wisdom of the Body" offers physicians an eloquent refresher on human biology.

Reviewed by Lee J. Engfer

Even if you *have* ever plunged your hand into the blood-filled abdominal cavity of a severely hemorrhaging patient and, with blind instinct, felt your way through to stop the deadly bleeding—could you then write about it in compelling prose? Surgeon Sherwin B. Nuland does so in a riveting account that opens "The Wisdom of the Body" (Alfred A. Knopf, 1997), the sixth book by the author of the best-selling "How We Die."

Having established himself in the first chapter as a hero and authority whose hands—and narrative—a reader can trust, Nuland, clinical professor of surgery at Yale University, goes on to conduct "grand rounds" of the human body. His discussion of such topics as major organs, the cell, reproduction, and cancer may be back-to-basics for physician readers, but even the most jaded will find inspiration in Nuland's tremendous enthusiasm, awe, knowledge, and appreciation of his subject.

Named one of the Best Books of 1997 by *Publishers Weekly* magazine, "The Wisdom of the Body" spills over with erudite asides, fascinating bits of trivia, and amazing facts. Did you know that the typical human cell synthesizes some 20,000 distinct types of protein molecules, about 2,000 of which are present in quantities of 50,000 or more identical copies? "Such a staggering figure gives us some idea of the swarming immensity of biochemical activism within us, all in the service of con-



SHERWIN B. NULAND

AUTHOR OF *HOW WE DIE*

stant vigilance and response in order that life may continue," Nuland writes.

Nuland also likes his etymology: Noting that the word *artery* derives from the Greek word meaning "air duct," he touches on the "fanciful formulation" the Greeks came up with to "explain away the obvious fact that arteries bleed when cut."

One of Nuland's greatest passions lies in his own area of specialization, the belly: "The duodenum, jejunum, and ileum are a triumph of architectural design," he writes. "Obviously, this can be said about every other organ of the body as well, but the humble gut is so rarely acclaimed that it has consistently been under-

valued in the pantheon of nature's masterpieces. Being one of its most intimate admirers, I feel called upon to redress this wrong."

Beyond detailing the biological wonders of the body, Nuland seeks to illuminate its *wisdom*—the "beautiful mystery" of the human spirit. For Nuland, that quality is inseparable from its material substance. He looks to that "swarming immensity of biochemical activism within us" to find the essence he calls spirit: "the product of the organization and integration of the multiplicity of physical and chemical phenomena that is us. It has to do with the way the various parts of the human body communicate and are coordinated with one another under the control of the evolved masterwork that is the human brain."

The body's constant struggle to maintain constancy in a sea of instability and change results in a never-ending flow of cellular communication, an awareness that makes us more than the sum of our parts. Nuland writes: "On every level of our comprehension of the world within us and the world without, influential signals are constantly moving to and fro, bringing into the deepest part of us messages from outside our bodies, while at the same time allowing even our cellular needs to be known, whether directly or indirectly, by the conscious mind. It is the integration of each separate part into the whole that constitutes the leading characteristic of the wisdom of the body." ➤



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Nuland allows himself a few indulgences, such as his wife's fawning description of him when he returns home adrenaline-pumped from surgery. Still, it's possible to forgive him these flaws, the way you would a favorite (and somewhat old-fashioned) professor. And, with his experience and intelligence, Nuland would seem to be the ideal teacher. Luckily, you don't have to go back to medical school to take his refresher course on the everyday miracles of flesh and blood. **MM**

Lee Engfer is an associate editor of Minnesota Medicine.

Minnesota Medicine

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People and Places Making Medical News

People

'U' Medical School Selects Associate Dean for Research

Charles Moldow, M.D., has been named associate dean for research at the University of Minnesota Medical School. Moldow is a professor of medicine at the university and has been chief of staff at the Minneapolis Veterans Administration Medical Center since 1996.

Moldow will oversee the school's research activities, coordinate distribution of research information, and manage research grants.

MAFP Elects 1998-99 Officers

Patricia J. Lindblom, M.D., of Fergus Falls was elected president-elect of the Minnesota Academy of Family Physicians by the organization's House of Delegates in April. She will assume the presidency next year. David C. Thorson, M.D., of White Bear Lake was installed as president.

Other newly elected officers are Keith L. Stelter, M.D., Moose Lake, speaker of the house; Nicholas P. Bernier, M.D., Brainerd, vice speaker; Paul Van Gorp, M.D., Long Prairie, alternate delegate to the American Academy of Family Physicians; Terence P. Cahill, M.D., Blue Earth, board chair. Reelected were Jamie Peters, M.D., Minneapolis, vice president; Raymond G. Christensen, M.D., AAFP delegate; and Pamela G. Dumke, M.D., Maple Grove, treasurer.

'U' Cardiologist Chosen AAAS Fellow

Jay Cohn, M.D., professor of medicine at the University of Minnesota, has been elected a fellow of the American Association for the Advancement of Science for his contributions to the study of heart failure. Cohn co-founded the Heart Failure Society of America in

1996 and is currently president. He developed the Rasmussen Heart Failure Treatment Center at the university.

Mayo Physician Named ACP Master

Edward C. Rosenow III, M.D., of Rochester was one of 39 masters named by the American College of Physicians at a ceremony during the 79th Annual Session in San Diego in April. Mastership is the highest level of membership in the organization of internists.

MMRF Appoints New Board Members

The Minneapolis Medical Research Foundation, a subsidiary of Hennepin Faculty Associates, has appointed eight new members to its board of directors. They are Joseph E. Clinton, M.D., chief of service for the emergency medicine department at Hennepin County Medical Center; Myron L. Frans, an attorney with Gray, Plant, Mooty, Mooty & Bennett, P.A.; Donald M. Fraser, former mayor of Minneapolis; Mehmood A. Khan, M.D., division chief for endocrinology, metabolism, and nutrition at HCMC; Robert H. Paymar, chair and principal owner of Dougherty Summit Securities LLC; Frank L. Sims, president of Cargill North American Grain Division; Jana M. Stender, a partner at the Carmichael Lynch Spong public relations firm; and David N. Williams, vice-chair for the internal medicine department at HCMC.

HealthSystem Minnesota Names Top Educator, Researcher

The Institute for Research and Education HealthSystem Minnesota named Park Nicollet Clinic neurologist Frederick R. Taylor, M.D., Educator of the Year. Taylor is director of the Comprehensive Head and Neck Pain Clinic at Park Nicollet Clinic. The institute recognized Richard M. Bergen-

stal, M.D., a Park Nicollet Clinic endocrinologist and executive director of the International Diabetes Center, as Researcher of the Year. The Institute for Research and Education is part of HealthSystem Minnesota.

Places

United Hospital Teams with Church to Provide Translation Services

A coalition of churches led by Sacred Heart Catholic Church on St. Paul's East Side has joined with United Hospital to improve services for the hospital's non-English-speaking patients. The hospital hired a full-time interpreter for Spanish-speaking patients, put up brochures in Spanish, Hmong, Vietnamese, and Russian, and started a program to reimburse employees who want to learn Spanish.

Socioeconomics

Nonprofessional Health Care Workers Are Organizing

While nurses have long been union members, other health care workers—nursing assistants, lab technicians, x-ray technicians, secretaries, receptionists, and other support staff—are beginning to organize in the Twin Cities.

In April, nonprofessional and nonsupervisory workers at Mork Clinic in Anoka voted to strike if no agreement was reached between clinic management and negotiators from Service Employee International Union Local 113. A group of pharmacists, also members of Local 113, reached an agreement with Regions Hospital hours before a strike deadline. In the past year, Local 113 has organized nine or 10 bargaining units, according to a *Saint Paul Pioneer Press* article. Key issues are improved wages and working conditions.

Nationally, Service Employee International Union has been one of the most successful organizers, particularly among low-paid workers, women, and minorities, according to the *Pioneer Press*.

Detox Center Will Ban Smoking

The Ramsey County Board has decided to ban smoking by both staff and patients at the 50-bed Ramsey County Detoxification Center beginning in July. "We are a health care facility, and smoking is hazardous to your health," Donald Mockenhaupt, a county Human Services director who oversees the detox center, said in a *Saint Paul Pioneer Press* article. "It's going to be quite a change."

Gubernatorial Candidates Say No to Tobacco Money

Nine candidates running for governor in Minnesota have promised that they will not accept campaign contributions from tobacco industry employees or lobbyists. The candidates who signed the pledge, sponsored by the Minnesota affiliate of the American Heart Association, are St. Paul Mayor Norm Coleman (Republican); Sen. John Marty (DFL-Roseville); Jesse Ventura (Reform Party); Sen. Doug Johnson (DFL-Tower); Mark Dayton (DFL); Hennepin County Attorney Mike Freeman (DFL); Attorney General Hubert Humphrey III (DFL); Ted Mondale (DFL); and Allen Quist (Republican).

Twelve Percent of Ramsey County Residents Are Uninsured

More than 12 percent of Ramsey County residents have no medical insurance, according to a report presented to the County Board in April. The majority of the uninsured residents are between the ages of 25 and 44. Some are working but do not have insurance through their employers.

About 1.3 percent of Ramsey County residents have Minnesota-Care coverage, compared with the 2.6 percent statewide average. County Board Chair Susan Haigh

said it appears that some people who would be eligible for Minnesota-Care prefer not to get it. "To some of the working poor, it sounds like welfare. There has to be a way to encourage people to apply," she said in a *Saint Paul Pioneer Press* article.

The report says that Regions

Hospital, which is owned and operated by HealthPartners, provides the vast majority of care to uninsured Ramsey County residents. Most uninsured people go to what historically was the county's public hospital. People without insurance also tend to

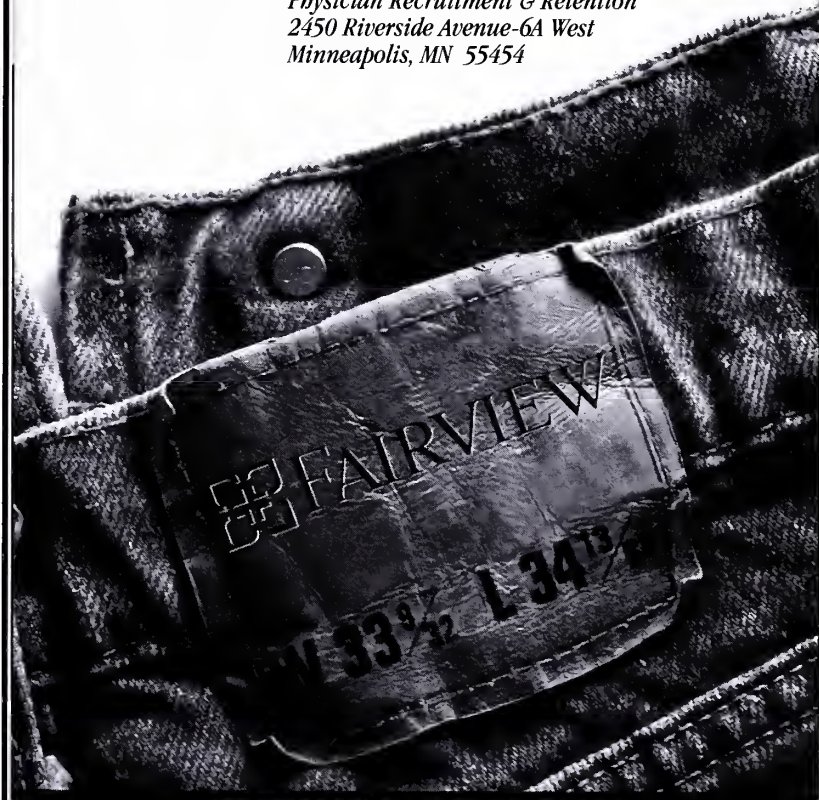
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overuse emergency departments, since they don't have a primary care doctor.

In 1996, Regions had \$21 million in charges for uninsured patients, compared with less than \$5 million for St. John's, St. Joseph's, United, and Children's hospitals combined. HealthPartners absorbs most of those costs.

The report's recommendations include outreach efforts to encourage more people to use Minnesota-Care, communication with other county hospitals to determine how they could share more of the burden of serving patients without insurance, and establishing more urgent-care centers.

Medicare Managed Care Numbers Will Exceed 20 Percent by 1999

Enrollment in Medicare managed care plans will exceed 20 percent by the end of 1999 as a result of reforms in the Balanced Budget Act of 1997, according to health industry consultant Howard Veit, managing principal for Towers Perrin. Medicare seniors will have a wide array of health plan choices, Veit said, and the health care system will become increasingly retail-oriented as health care organizations compete aggressively for market share.

"We expect legislators on both federal and state levels to take a growing interest in protecting consumers from perceived or potential problems with health plans, and they may well limit the flexibility of managed care vendors," Veit said. "As a result, consumers will seek better access to information about their health care and how their plans operate."

Veit said the Balance Budget Act opens the door for physicians and hospitals to sponsor their own health plans, including PSOs, which will make competition even more dynamic.

Rates, Trends, Data

.....

Accidents Killing Fewer Children

The number of children dying

from accidents such as car and bike crashes has decreased 26 percent in the last decade, due in large part to an increased use of seat belts and bike helmets. However, injury rates for sports-related activities such as basketball, football, and in-line skating are up, according to a report from the National Safe Kids Campaign.

The overall death rate from accidental injuries was 15.56 per 100,000 children aged 14 and under in 1987. By 1995, the rate had fallen to 11.45 per 100,000—a 26.4 percent drop.

Gangs, Violence Rising in U.S. Schools

Nearly twice as many U.S. teens reported gangs in their schools in 1995 as did in 1989, and the number of students victimized by violent crime increased nearly 25 percent, according to the Bureau of Justice Statistics and the National Center for Education Statistics.

Violent crime at school—physical attacks or robbery—was reported by 4.2 percent of students in 1995, up 23.5 percent from 1989. This difference represented an increase of about 270,000 students.

The gang increase came in every type of community: central cities, suburbs, and nonmetropolitan areas. Sgt. Mike Martin, a supervisor in the Minneapolis police gang unit, said gang activity in Minneapolis schools appears to be at a plateau. "We've not seen a significant increase in the number of students involved in gangs," Martin said in a *Star Tribune* article. But investigators have seen an overall increase in violence in Minneapolis schools and a drop in the age of students involved in gang activity.

Many MA Kids in HMOs Did Not Get Shots

Less than half of the 2-year-old children enrolled in HMOs serving people on Medical Assistance received their full set of recommended immunizations in 1996, two state studies show. In con-

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trast, 65 percent of the 2-year-olds covered by commercial HMOs received all their vaccinations.

Several county health agencies are experimenting with registries to track patient immunization histories, but consumer advocates say that more effective outreach to the Medical Assistance population is needed. Blue Cross and Blue Shield of Minnesota has begun contracting with public health agencies, which have more experience reaching out to patients to get them into the clinic.

Medical Research

Researchers Will Study Post-Flood Health Problems

Researchers in Grand Forks, North Dakota, plan to spend the next two years studying the health effects of last spring's flood. Grand Forks public health director Don Shields said he has reports of more premature births and miscarriages than usual since the flood. He also said he expects to see an increase in mental health problems. Researchers will look at medical, school, and police records dating back two years before the flood.

Report Links Adolescent Drug Abuse to Abusive Home

A study by the Minnesota Department of Human Services shows a strong link between multiple-drug abuse by adolescents and a home life involving parents who engage in physical and sexual abuse and drug abuse. The most serious adolescent drug abusers also have high rates of truancy, vandalism, sexual activity, psychological problems, and suicide attempts.

The report, "Substance Use in Adolescence: Patterns and Profiles," by Patricia Harrison, Ph.D., was based on 1995 Minnesota Student Survey responses by nearly 125,000 students aged 11 to 18.

"The study shows it's critical to reduce these risk factors, which affect serious substance abuse among adolescents," said Harrison. "While all young people

may be at risk of using drugs, those with serious psychological stress at home are at much greater risk. Education about the dangers of drugs isn't enough to deter troubled kids from using. We need to provide intervention services that help them keep drugs out of already difficult lives."

Community Hospitals Treat Stroke with Thrombolytic Therapy

Use of the first treatment for acute stroke is effective in a community setting, according to a study released during the American Academy of Neurology Annual Meeting, which took place in Minneapolis April 25 to May 2. The ongoing study has followed patients treated with the clot-busting drug tissue plasminogen activator (tPA) since January 1996 at 31 hospitals in Minnesota.

When the National Institute of Neurological Disorders and Stroke reported its findings on the use of tPA for stroke, many physicians questioned whether smaller community hospitals could manage the complex issues and potential hemorrhage risk. The new results show that the difference in outcomes between patients treated at larger, academic hospitals and those treated at smaller community hospitals is not statistically significant.

Study Will Test Health Effects from Arsenic in Well Water

The Minnesota Department of Health has launched a study that should make it easier to predict whether a private well may contain naturally occurring arsenic. It will also assess the potential health impact of consuming water that contains very low levels of arsenic over an extended time period.

Known as the Minnesota Arsenic Research Study, the project will be conducted in a five-county area of west-central Minnesota, where past testing has detected low levels of arsenic. The University of Minnesota and Hennepin County Medical Center are collaborating with MDH on the study. □

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Identifying Hunger Important in Pediatric Care

Pediatricians who serve low-income children should assess patients for hunger, according to a Minneapolis Medical Research Foundation study published in the May *Archives of Pediatric and Adolescent Medicine*. A better understanding of the characteristics of hunger among young children is needed in order to improve identification, intervention, and prevention of hunger-related diseases, said the study author, Diana Cutts, M.D., of the Hennepin County Medical Center Department of Pediatrics.

Researchers studied 2,578 children under age 5 who received care at HCMC ambulatory pediatrics clinics. The clinics serve an inner-city population that is predominantly low-income and ethnically diverse. Results showed that 7 percent of the children were hungry and an additional 33 percent came from families at risk for becoming hungry.

The study showed several

factors were associated with hunger status. Children in the hungry group were more likely to have mothers who 1) were non-white, 2) had no post-high school education, and 3) were separated or divorced and/or had a history of homelessness in the past year. Nearly 40 percent of the families who were hungry or at risk for hunger had at least one employed adult. Children who were hungry were no more likely to be underweight or overweight than children who weren't hungry. All assistance programs, with the exception of WIC, were more likely to be used by the hungry and at-risk groups.

AIDS Patients on Protease Inhibitors May Be at Increased Risk of Heart Disease

The protease inhibitors used to treat AIDS patients appear to drive up the levels of artery-clogging fats, increasing the risk of heart disease, according to research published in the journal *Lancet* by Keith Henry, M.D., medical director of the HIV/AIDS program at Regions Hospital in St. Paul.

After a 26-year-old AIDS patient suffered a heart attack and a 37-year-old developed blockages in the arteries on both sides of his heart, physicians at Regions tested 124 patients on protease inhibitors. One-third of them had the same kind of cholesterol and triglyceride problems.

Henry recommends that patients on the drugs be placed on the standard cholesterol-lowering protocol: increased exercise, low-fat diets, and drug therapy.

However, Henry said more research is needed and questioned whether this standard treatment will work the same in AIDS patients as in others. The protocol has lowered cholesterol for some of his patients, but not all. Henry said he and his colleagues are debating whether to discontinue or at least cut back on protease inhibitors when cholesterol treatment doesn't work.

"As the prognosis for people [infected with the AIDS virus]

improves, we don't want to create a scenario in which we avoid death from one disease only to increase deaths from the No. 1 killer in the United States, heart disease," said Henry in a recent Minneapolis *Star Tribune* article.

Some Foreign Adoptees May Need Vaccinations

Children adopted from China, Russia, and Eastern Europe may need to be vaccinated against illnesses such as diphtheria, pertussis, and tetanus despite having immunization records saying they are fully immunized, according to researcher Margaret Hostetter, M.D., and colleagues from the University of Minnesota's International Adoption Clinic. A study she conducted found that only 38 percent of 55 children tested had developed antibodies against the illnesses even though their records said they had received the DPT immunization. She presented her findings at the Pediatrics Societies of America annual meeting in New Orleans.

Hostetter and her colleagues developed recommendations for physicians and parents of foreign adoptees. Although the study focused on children from China, Russia, and Eastern Europe, results for children from Thailand and Vietnam were variable, so the recommendations apply to these children, as well. Children from Korea and India tend to be fully immunized. The researchers did not test children from Central and South America.

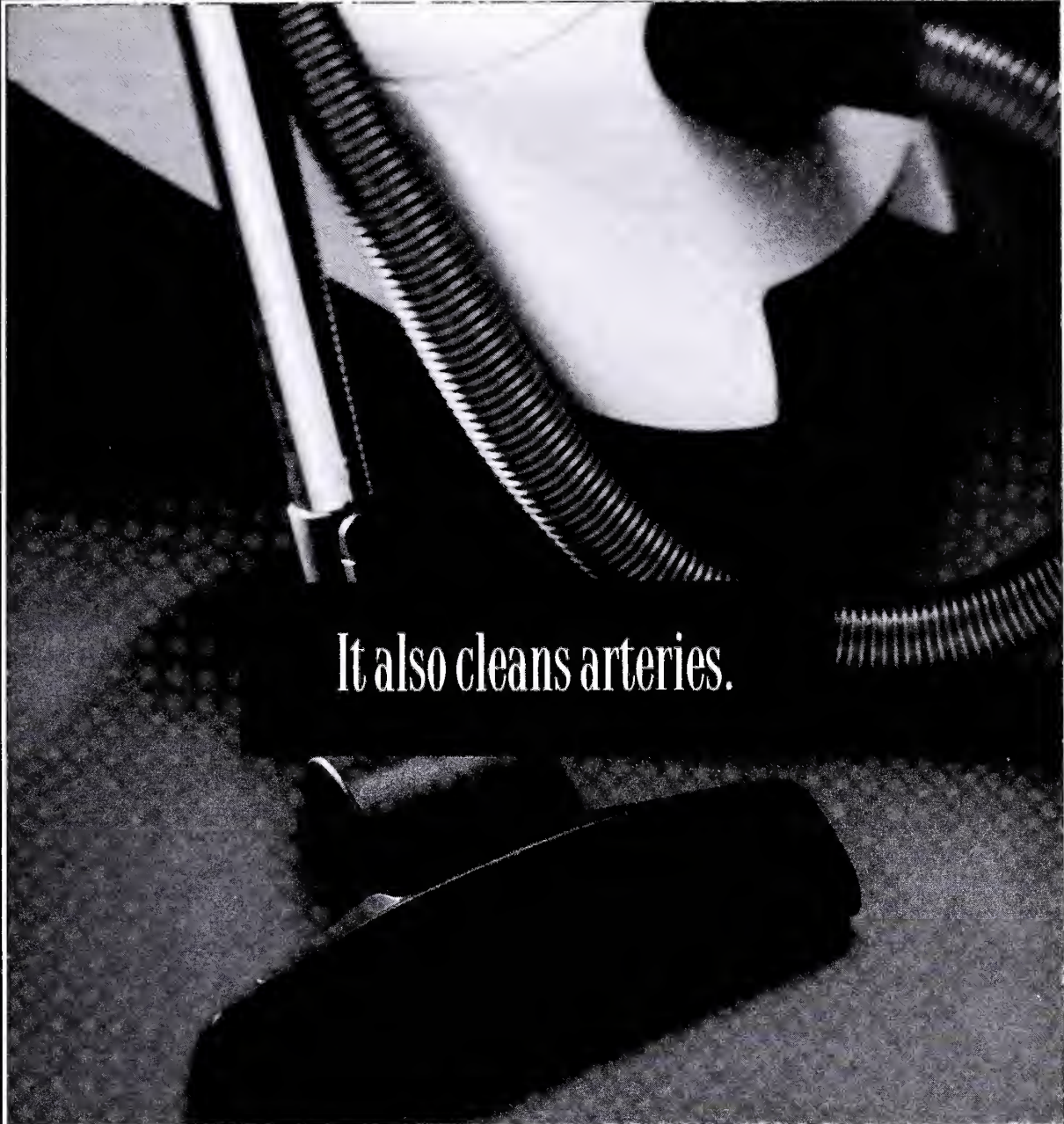
Hostetter and her colleagues recommend that:

1) If a child has had fewer than three DPT vaccinations, restart the series.

2) If the immunization record says a child has received more than three DPT vaccinations, do an antibody test. If the antibodies are appropriate, pick up the series from that point. If the antibodies are not adequate, restart the series.

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JUNE 1998

June 4-6 **Fifth Annual Mayo Interventional Cardiology Symposium** Mayo Foundation; Leighton Auditorium, Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 4-6 **Workshops in Clinical Hypnosis** University of Minnesota/Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 5-6 **Annual Spring Sports Medicine Conference** University of Minnesota, Minneapolis Sports Medicine Center; Holiday Inn Metrodome, Minneapolis, MN. CONTACT: Bob Finke, 701 25th Avenue S, Suite 150, Minneapolis, MN 55454; 612/672-4800.

June 12 **Treatment of Addictive Disorders** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13 **New Options for Erectile Dysfunction** University of Minnesota/Continuing Medical Education; Bloomington Marriott, Bloomington, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13 **Prostate Microwave Training Course** Abbott Northwestern Hospital Institute for Minimally Invasive Technologies; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

June 17-19 **Topics and Advances in Pediatrics** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar,

Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 17-20 **62nd Annual Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota Medical School Department of Surgery; Willey Hall, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 800/776-8636.

June 25-27 **First Annual Meeting International Society for Minimally Invasive Cardiac Surgery** Minneapolis Heart Institute Foundation; Marriott Hotel-City Center, Minneapolis, MN. CONTACT: Julie Page, Allina Clinical Education and Research Administration-81475, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440; 612/992-3897.

JULY 1998

July 16-18 **Management Strategies in Hematologic Oncology** Mayo Medical Laboratories; Ihilani Resort and Spa, Kapolei, Oahu, HI. CONTACT: Kathy Bates, 200 First Street SW, Rochester, MN 55905; 507/284-3942.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

June 23 **Infection Control** Hennepin County Medical Center; HCMC, Pillsbury Auditorium, Minneapolis, MN. CONTACT: HCMC CME, 701 Park Avenue, Mail Code 861B, Minneapolis, MN 55415; 612/347-2075, toll-free 888/263-4262.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Julie Page, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

July 17-19 **Fifth Annual Course on Lasers in Cutaneous and Cosmetic Surgery** University of Minnesota/Continuing Medical Education, Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue SE, Minneapolis, MN 55414; 800/776-8636.

SEPTEMBER 1998

Sept. 13-18 **Advances in Diagnostic Radiology and Advanced Radiology Life Support Course** Mayo Foundation; Banff Springs Hotel, Banff, Alberta, Canada. CONTACT: Office of Continuing Medical Education, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Clinical Autonomic Quantitation Workshop** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Office of Continuing Medical Education, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

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Use your money wisely. For personal attention and lease or purchase information on any vehicle, call 612/623-2860, or toll-free 800/298-MMBR.

MMBR Motor Services is a service of Minnesota Medical Business Resources, a physician-owned corporation of your medical association.

New Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
98 Chevrolet Blazer LS 4dr	\$27,847	\$25,476	\$438	\$385	\$367	\$338
98 Ford Explorer XLT 4dr	\$28,285	\$26,097	\$496	\$425	\$376	\$341
98 Nissan Pathfinder SE	\$30,589	\$28,293	\$546	\$467	\$416	\$372
99 GMC Yukon SLE 4dr	\$34,738	\$31,970	\$444	\$396	\$376	\$357
99 Chevrolet Tahoe LS 4dr	\$34,119	\$30,952	\$430	\$385	\$367	\$348
99 Chevrolet Suburban 1/2 LS	\$37,098	\$33,085	\$498	\$448	\$412	\$399
97 Toyota 4-Runner SR5 4dr	\$31,900	\$30,600	\$594	\$455	\$425	\$386
98 Jeep Gr. Cherokee Laredo 4dr	\$28,440	\$26,800	\$502	\$437	\$389	\$355
98 Ford Expedition XLT 4dr	\$31,700	\$29,287	\$477	\$415	\$377	\$352

Effective date 4/8/98

* Sale price before tax, license, and license fees.

** All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a \$0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.



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